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Roster of Editorial Board appears in this issue at beginning of California Medical Association department. (For page number see index below.)

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Leaflet Regarding Rules of Publication.—CALIFORNIA AND WESTERN MEDICINE has prepared a leaflet explaining its rules regarding publication. This leaflet gives suggestions on the preparation of manuscripts and of illustrations. It is suggested that contributors to this Journal write to its offices requesting a copy of this leaflet.

DEPARTMENT INDEX

(Itemized Index of Articles is printed on Front Cover)

EDITORIALS

72ND ANNUAL SESSION: AT LOS ANGELES, MAY 2-3, 1943

The current issue of the OFFICIAL JOURNAL is in press at the time this year's annual session is being held in the Hotel Biltmore, Los Angeles, on Sunday, May 2nd and Monday, May 3rd. The April issue contained the complete program. All indications point to general and section meetings that will be of interest and value.

The Committee on Scientific Work is indebted to military authorities who are associated with the medical departments of the Army and Navy, and to colleagues in the active service with the Armed Forces, for generous coöperation; not only in connection with papers that will be given on topics related to military medicine but also in making possible the presentation of exhibits and films dealing with military subjects.

Conforming to custom the June issue will present complete reports of the proceedings of the House of Delegates, the Council, and will also give information on other matters of special interest. During the coming year, many of the papers will receive place in the text pages of CALIFORNIA AND WESTERN MEDICINE, so giving members who were not able to attend an opportunity to partake, if only by indirection, somewhat of the spirit of this session in which military and related medicine will be emphasized.

PRE-CONVENTION BULLETIN

Reports by the County Society Secretaries.—The April issue of CALIFORNIA AND WESTERN MEDICINE contained the "Pre-Convention Bulletin" in which appeared two major groups of reports: (1) Reports of Officers and Committees (pp. 181-203), and (2) Reports of the Component County Medical Societies (pp. 204-212).

Attention of members is directed to these important summaries, the hope being expressed, if time has not been available for their perusal, that the issue may be laid aside for future consideration. A hasty glance at the topics presented by the many workers of the Association whose names are signed to the communications, is reassuring evidence that the medical profession continues to have many disciples who gladly give of their best in promotion of activities that are designed to conserve the interests of the public health and medical standards.

The reports submitted by the secretaries of the forty component county societies,—which

make up the federacy, league or alliance known as the California Medical Association—are of special interest under present conditions, and furnish profitable reading for all county society officers. Since, what one county society is able to do, should be worthy of careful consideration by other county units.

The strength of organized medicine comes back in good part to the county medical societies, since these are the basic units through which membership in state and national organizations is determined. Also, these county groups, with jurisdiction in their respective geographical areas and communities, set the patterns and standards whereby the medical profession is judged by lay citizens. True, the estimate of the lay public is also based in large part on the professional and civic services rendered by individual physicians. It is important to recognize, however, no matter how excellent may be the reputations of individual practitioners in any community or county, that as regards the organized profession of medicine, a community spirit among physicians themselves must be existent, if the standards of scientific medicine are to be properly appreciated, and the good will of the community, secured.

* * *

Organized Medicine Conserves Scientific Medicine.—It must not be forgotten that during the last decade or so, a persistent campaign has been carried on in many quarters to break down the esteem in which the medical profession was formerly held by the great majority of citizens. The protection against such undeserved onslaughts necessarily falls upon the component county societies. The State and National Associations can coöperate in measures designed to protect the best interests of the public health and of the standards of scientific medicine, but the real support resides within the membership of the component county units. That is why the county society reports presented in the April issue are worthy of special perusal.

It is heartening to read of the many activities of the county societies, and to note the spirit of loyal and generous endeavor which animates the physicians throughout the length and breadth of California. Therein lies the hope of the profession in the battles still ahead.

ON PROCUREMENT OF MEDICAL OFFICERS FOR THE ARMED SERVICES

Report on an Address by Captain Philip K. Gilman.—On Tuesday, April 20th, Captain Philip K. Gilman gave an address before the Commonwealth Club of San Francisco. In its report thereon, in the issue of April 23rd, the *San Francisco Examiner* made two erroneous statements, which it acknowledged when called to its attention:

A portion of the letter sent to the *Examiner* follows:

"Your attention is called to the report concerning the address given by Capt. Philip K. Gilman, U.S.N.R., who is the medical officer in charge of the northern division of the United States naval office of naval officer procurement. (Doctor Gilman is not a former president of the California Medical Association, but for some years has been the chairman of its council.)

"The item stated: 'Nine hundred doctors must be recruited immediately from northern California, and three hundred from the southern part of the State.' This is the reverse of what Captain Gilman stated, and the error should be corrected.

"It is unfortunate that your reporter also deemed it necessary to inject the statement that Doctor Gilman 'gave no explanation of why hundreds of Army and Navy doctors are sitting around doing little or nothing, while hundreds of others are being used, not for medical work, but for paper work.'

"There was nothing in Captain Gilman's remarks to warrant the above statement, which is most detrimental to the efforts of the surgeon generals of the Army and Navy to build up their respective medical corps so that the best medical and surgical service may always be available to soldiers and sailors in our armed forces.

"It should be remembered that, just as it is necessary to maintain in continental America a pool of millions of men who are being trained so that they may be available for military work, so also is it equally important that an adequate pool of medical officers and personnel be likewise available, in case occasion should demand, that they could be called upon for instanst service, either on the American continent, or in foreign lands."

A paragraph in the letter that was not printed by the *Examiner*, stated:

"I feel sure you will agree that it is vital to our Country's best interests that misconceptions in matters such as the above should not be spread. May we hope that *The Examiner* will take occasion to promptly rectify the erroneous impressions given in the article referred to?"

* * *

Reply by the Editor of the "San Francisco Examiner."—It is interesting to note the comments contained in the reply of the *Examiner* editor (printed in black face type):

"(Editor's Note: The errors regarding Doctor Gilman's title and the transposition of figures on recruiting in northern and southern California are herewith acknowledged. The statement that both Army and Navy are hoarding, misplacing and misusing hundreds of doctors is hereby reiterated. The whine about needing to train doctors is an evasion of the facts. Doctors who are doing little or no work in the Army and Navy, doctors who are doing work that could be done by any intelligent stenographer and doctors who are being used for executive work that could be done by laymen are not being trained; they are being wasted. Doctors lying around for lack of equipment should have been left in civilian life until the equipment was ready. Finally, thousands of doctors, according to doctors in the military service, are being used for medical work that utterly wastes their years of training as specialists. Orthopedists (bone specialists) examine recruits, surgeons sit at desks, nose and throat men do obstetrics or paper work. Some of this is in the process of correction, but the process is slowed by the wholesale recruiting of doctors before the Army and Navy have even half digested those already in the service.)"

Physicians have a Different Opinion of the Situation.—Members of the California Medical Association have been repeatedly informed concerning the need for adequate medical personnel for the armed forces by the United States Army and Navy, through the official and other notices appearing in the *Journal of the American Medical Association* and CALIFORNIA AND WESTERN MEDICINE. The California Procurement and Assignment Service (Dr. Harold Fletcher, San Francisco, chairman, and Dr. Edward M. Pallette, Los Angeles, vice-chairman) has also kept the component county societies and physicians generally, in touch with immediate and prospective needs, and the status of California in the quotas assigned to the States of the Union.

The opinions expressed by the *Examiner* may be shared by a limited number of individual physicians, but there is nothing on record to indicate that they are accepted by the great majority of physicians of California, in either military or civilian service.

* * *

An Illuminating Letter from the War Manpower Commission's Procurement Division.—Perhaps the best answer to the *Examiner's* statements may be found in a letter received while the above comments were being sent to the printer. The communication, dated May 6, 1943, comes from President Roosevelt's War Manpower Commission and is signed by Doctor Frank H. Lahey, recent president of the American Medical Association who, as chairman of the Directing Board of the national Procurement and Assignment Service, is in possession of facts and figures that permit him to speak with authority. Doctor Lahey's letter follows, the attachments with statements by the Surgeon Generals of the United States Army, Navy and Public Health Service appearing in the War Effort Department in this issue (on page 281):

(COPY)

WAR MANPOWER COMMISSION
Office for Emergency Management
Procurement and Assignment Service for Physicians, Dentists, and Veterinarians
Washington, D. C.

May 6, 1943.

Dear Doctor Kress:

Attached are statements pertaining to the procurement of physicians to meet the nation's military and civilian needs, prepared by the surgeons general of the Army, Navy and the U. S. Public Health Service, and the chairman of the Directing Board of the Procurement and Assignment Service for Physicians, Dentists and Veterinarians.

The failure of some areas in the country to provide their quota of physicians for the armed forces reflects unfortunately on all of American medicine. Is American medicine incapable of making the sacrifices required of it without compulsion?

We must face one inescapable fact. Our fighting men, and those who must remain behind, must and will have medical care. It will be obtained one way or another. The choice of methods is still in our hands. The medical profession of this country never has failed the nation: it must not do so now!

The Directing Board of Procurement and Assignment Service seeks your further aid in the recruiting task that is before us by requesting that you publish in the next issue of CALIFORNIA AND WESTERN MEDICINE the four statements that are attached. (Editor's Note. The four statements appear in this issue in the department of the California Committee on Participation of the Medical Profession in the War Effort. See page 281.)

An editorial in the same issue calling attention to these statements and some of the considerations referred to in this communication, also would be most helpful.

The Directing Board is most grateful for the aid you already have extended them and for that which it knows you will continue to extend.

Very truly yours,
(Signed) FRANK H. LAHEY, M. D.,
Chairman, Directing Board.

EDITORIAL COMMENT†

DEPOLYMERIZED ANTIBODIES

The first recorded instance of a specific antibody definitely increased in titer by chemical alteration of serum proteins is currently reported by Eggerth[1] of the Department of Bacteriology, Long Island College of Medicine.

Antibodies have been previously modified by various chemical agents, such as acids, alkalies, formaldehyde, or by combination with diazo compounds. Such modifications have almost invariably reduced specific titer or destroyed one or more of the specific reacting properties. Thus Eagle[2] found that one part of formaldehyde in 1,000 parts of diphtheria antitoxin would completely inhibit its flocculating activity, without reducing its therapeutic titer. Weil[3] treated antibodies with acids and found that they had lost most of their ability to fix complement. Antibodies have also been modified by partial digestion with pepsin,[4] trypsin[5] or other digestive enzymes. Coghill,[6] for example, partially digested diphtheria antitoxin with Takadiastase, and thus prepared a therapeutically effective "refined antitoxin" whose original horse specificity was so altered that it no longer gave anaphylactic reactions on injection into guinea pigs previously sensitized to native horse proteins. This he interpreted as indicating that part of the antibody-molecule is immunologically inert, and that the functional portion is practically unaltered by such partial digestion.

Ninhydrin has been used for a generation for the qualitative and quantitative determination of amino groups. Its method of action on serum proteins has been fairly well determined. In his earlier work Eggerth[7] found that while ninhydrinized antityphoid horse agglutinins had lost about

† This department of CALIFORNIA AND WESTERN MEDICINE presents editorial comments by contributing members on items of medical progress, science and practice, and on topics from recent medical books or journals. An invitation is extended to all members of the California Medical Association to submit brief editorial discussions suitable for publication in this department. No presentation should be over five hundred words in length.

45 per cent of their original amino nitrogen and were no longer coagulable by heat at reactions higher than pH 5.5, they often retained their full agglutinating titer. Since then ninhydrinization has been applied to rabbit serums. In his latest technique, antityphoid rabbit serum is dialysed against a phosphate buffer solution, and the serum "dilated" to three times its original volume with the same buffer. One volume is freshly prepared 1 per cent ninhydrin solution in distilled water is then added and the mixture incubated for two hours or more at 37°C. The protein precipitate that forms on this addition may either be removed and the serum fractionated, or retained and eventually redissolved by dialysis against distilled water.

In a typical experiment a rabbit serum having an original typhoid H-agglutinin titer of 1:10,000 had its titer increased three-fold by the end of 30 minutes of this incubation, and further increased to 1:40,000 (four-fold) by the end of 2 hours. Incubation for 18 hours reduced the titer to the 30 minutes three-fold level (1:30,000). Every rabbit antiserum thus far tested showed this increase, though not always to the same degree. The serum showing the greatest increase was from an animal that had been under periodic immunization for over a year. On fractionation of the ninhydrinized serum most of the H-agglutinin was demonstrable in the "salt-soluble portion of the acid precipitate." This portion contained only 14 per cent of the original serum proteins. While the original untreated immune serum contained 1,100 H-agglutinin units per mg. of total N, and the 30 minutes ninhydrinized whole serums contained 3,300 such units, the salt-soluble fraction contained 16,000 units per mg. N.

Isolation of the active principle of immune serums by a saltingout process is of course not new. The remarkable increase in antibody titer per mg. of total N as a result of ninhydrinization, however, is a phenomenon not previously described. Eggerston suggests four plausible hypotheses to account for this increase, the simplest being an assumed depolymerization or breaking down of large natural antibody aggregates into simple units, thus increasing the number of active molecules. Whether or not this theory is confirmed, the possibility of improving natural antibodies by simple chemical modification opens up a new field of immunochemical research of almost unlimited clinical promise.

P. O. Box 51.

W. H. MANWARING,
Stanford University.

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SPLENIC STREPTOLYSIN

Isolation of a splenic component with a high specific bactericidal action on hemolytic streptococci is currently reported by Nutini[1] and his coworkers of the Institutum Divi Thomae, Cincinnati, Ohio.

Autopsy spleens showing no gross pathological lesions were thoroughly minced and alternately frozen and thawed 3 times in an equal volume of Drew's solution. The material was passed through a Büchner filter, the filtrate centrifuged and the sediment discarded. To the clear supernatant fluid 95 per cent alcohol was then added periodically over an interval of several days to produce a final alcoholic concentration of 80 per cent. The secondary precipitate thus formed was filtered out and discarded. The resulting clear alcoholic solution was concentrated in vacuo at 30°C to the original volume of the Drew's solution and was then sterilized by passage through a Seitz filter. The resulting sterile filtrate was then evaporated to dryness, to get rid of traces of alcohol. The yield was about 2 g. of solid material per 100 grams of spleen. Solid material corresponding to 0.5 per cent of the Drew's extract added to 20 c.c. of beef-heart infusion agar completely inhibited the growth of all strains of hemolytic streptocci. Similar streptolytic titers were obtained with extracts from bovine spleens. Control tests showed no bactericidal effects of the human extract on pneumococci, staphylococci, or E. coli, indicating that the splenic bacteriolysin is at least relatively specific for streptococci. Since the active principle in this extract is thermostable and is not precipitated by 80 per cent alcohol, Nutini believes it is an entirely new immunity substance differing from the lysozymes and bacteriostatic enzymes of previous investigators.

Work is now in progress on the toxicity of the new splenic extract and its therapeutic efficiency on streptococcus infected animals.

P. O. Box 51.

W. H. MANWARING,
Stanford University.

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MEDICAL EPONYM

Sibson's Groove

Francis Sibson (1814-1876), while resident surgeon and apothecary to the Nottingham General Hospital, published a paper, entitled, "On the External Signs of the Position of the Lungs and Heart," in the *London Medical Gazette* (6:754-760, 1848). A portion of the article follows:

"In the healthy robust man the well-formed chest has certain prominences and depressions indicating the organs underneath. . . . A depression crosses the seventh and sixth costal cartilages from the lower end of the sternum to the fifth intercostal space. These depressions are just below the thoracic prominences; the right depression exactly indicates the lower margin of the right lung, while the left depression indicates the lower boundary of the heart."—R.W.B., in *New England Journal of Medicine*.

ORIGINAL ARTICLES

Scientific and General

TRAUMATIC SHOCK AND HEMORRHAGE*

L. A. ALESEN, M. D.
Los Angeles

SHOCK is a condition more readily described than defined. It may result from any one or more of a number of different causes—trauma, hemorrhage, burns, infection, exposure — but from whatever cause produced, the ultimate condition is characterized by decreased blood volume and volume flow, diminished cardiac output, arteriolar vasoconstriction, hemoconcentration, capillary dilatation and congestion, increased capillary permeability, and secondary fall of blood pressure. Other related factors, which usually accompany shock and serve to perpetuate and aggravate it, are deficient oxygenation or anoxia, hyperpotassemia, and deficient adrenocortical hormone.

RÔLE OF THE CAPILLARIES

Since the pathological and clinical features of shock, or peripheral circulatory failure, are due, in the last analysis, to deranged capillary function, and since the successful treatment of shock from whatever cause produced is directed towards restoring the fluid lost as the result of this deranged capillary function and, at the same time, improving that function, it is appropriate to direct attention to the capillaries as the fundamental unit involved.

The capillaries are finely-spun tubules consisting of a single layer of endothelial cells which constitute a semipermeable animal membrane. There are no smooth muscle or adventitial layers; however, special methods show the presence of the Rouget cells surrounding the capillary walls. These are cells of rather large nuclei and many thread-like fibrillary processes, which intertwine with each other and form a network around the capillary. These cells are thought to be of smooth-muscle origin and to produce capillary contraction. While there is undoubtedly some central nervous system control over their activity, it is pretty well agreed the capillaries possess a large degree of independent tonus and contractility.

The function of the capillaries is to provide a channel through which oxygen and nourishment may reach the tissues, and through which the waste products of metabolism may be discharged. In health, a fine balance between intravascular contents, tissue space and intracellular contents is maintained by several physical factors operating upon this semipermeable animal membrane which is the capillary endothelial wall. The intraarteriolar hydrostatic pressure is sixty millimeters of mercury. The osmotic attraction of the contained plasma protein, which is normally about seven per cent of the total plasma, is approximately forty millimeters of mercury, thus leaving a positive filtration pressure within the capillary wall of about twenty millimeters of mercury. On the venous side, the osmotic attraction of the contained plasma protein is about forty-five millimeters of mercury and the hydrostatic pressure ten millimeters, thereby leaving an osmotic attraction pressure of thirty-five millimeters of mercury. Under normal conditions, water, crystalloids and metabolic products pass back and forth over this animal membrane rather freely, but the larger protein molecules and the cellular elements of the blood pass with difficulty, if at all. The chief function of the plasma protein is to maintain the essential osmotic pressure within the capillary lumen at all times.

Some idea of the vast potential capillary bed may be gained by the statement that in the skeletal muscle of a man of normal size, the capillaries are approximately one hundred thousand kilometers in length, and have a total surface of sixty-three hundred square meters. Within these capillaries one cubic centimeter of blood is in contact with five to seven thousand square centimeters of capillary surface, thus providing the immediate proximity essential for the physiological exchange of nutriment and waste products.

Krogh[9] has shown that this vast capillary bed may contract and expand in response to physiological requirements or abnormal conditions. Lewis,[10] Moon[11] and others have demonstrated that the independent tonus and contractility of the capillaries respond promptly to trauma, thermal changes, chemical substances, deficient oxygenation and products of metabolism.

During normal physiological activity, such as muscular work, the products of metabolism affect the capillaries directly, causing them to dilate and thus permit an increased delivery of nutrition and oxygen, and an increased removal of waste products. But this physiological dilatation of the capillary is not accompanied by any increased or abnormal permeability of its wall.

The work of Moon[11] has been fundamental to an understanding of the mechanism of histamine shock and an explanation of the basic importance of capillary response in all forms of peripheral circulatory failure. Histamine, acetylcholine, as well as many other chemical substances, when introduced in small amounts under the skin cause a local capillary dilatation together with increased permeability accompanied by the development of a typical wheal. Moon[11] calls the wheal "shock in miniature." If sufficient capillary damage is done by this chemical injury, loss of intravascular fluid, water, plasma, and some cellular elements occurs, thus giving the typical picture of inflam-

* Read before the General Meeting, at the Seventy-first Annual Session of the California Medical Association, Del Monte, May 3-6, 1942.

From the Department of Surgery, College of Medical Evangelists, and the Surgical Service of the Los Angeles County General Hospital.

mation. This same picture is produced by bacterial poisons, physical agents, such as trauma, burns, or freezing. If now, histamine, acetylcholine, bacterial poisons or other toxins in sufficient quantity are diffused generally throughout the entire circulation, there is a widespread capillary damage with its resultant dilatation, increased permeability to plasma protein and its progressive tendency to form the complete picture of shock as first described. Thus, Moon[11] places great emphasis upon an "H-Substance" or histamine-like substance, in the explanation of all forms of shock. This H-Substance merely aggravates a normal physiologic mechanism into an exaggerated or pathologic response.

PATHOGENESIS OF SHOCK

1. Toxemia Theory. — As previously stated, Moon[11] explains the initiation of all shock upon the activity of an H-Substance which may be elaborated by the effect of trauma, heat or cold upon the body cells, by the deprivation of oxygen due to hemorrhage, or by action of bacterial or other poisons. Marked dehydration, as occurring in prolonged vomiting or diarrhea, acute infections, as pneumonia or typhoid fever, produce shock by their toxic effect on capillary endothelium. Whether or not his theory is in all respects correct, it is fundamental in that it places chief importance upon the capillaries as the basic pathologic unit in shock.

2. Theory of Nociceptive Nervous Stimuli.— O'Shaughnessy and Slome,[12] as the result of many experiments on cats in which the nervous impulses were interrupted by section of the nerves to the limbs and section and destruction of the spinal cord before the limbs were traumatized, found that the shock syndrome so produced was less severe than in the control group. They state, "we regard the two remaining factors, local fluid loss and the discharge of nociceptive nervous stimuli, as the effective etiological agents. The evidence does not allow us to dogmatize as to the relative importance of these factors, although we are inclined to believe that the nervous factor dominates the picture." Blalock[3] states: "The experimental evidence thus far indicates that nerve impulses are at least secondary in importance to the local loss of fluid in the initiation of shock which results from severe trauma to an extremity."

3. Suprarenal Hyperactivity and Hypoactivity. —Experimentally, Bainbridge and Trevan,[1] and Erlanger and Gasser[5] have produced vasoconstriction and shock by injection of adrenalin. They noted marked engorgement of the capillaries and venules of the intestinal villi. While vasoconstriction is doubtless an important accompaniment in most forms of shock, evidence seems to indicate that vasoconstriction alone is not sufficient to produce the typical syndrome of peripheral circulatory failure. Vasoconstriction is a protective mechanism to maintain adequate blood pressure for the vital centers in the face of decreasing blood volume. The failure of the adrenocortical hormone is probably of greater significance in the sustaining and aggravation of shock. Scudder[13] emphasizes this deficiency, particularly with reference to its control over potassium metabolism. He finds plasma potassium very much increased in practically all shock states, and considers that hyperpotassemia is one important factor in furthering capillary dilatation and permeability.

4. Local Loss of Blood and Fluid Theory.— Much experimental work has been done with particular reference towards determining the importance played by local loss of blood and fluid in the production of shock. Parsons and Phemister,[15] Blalock[4] and Bradburn, Beard[2] and Blalock, Hawkins and Harmon, and many others have contributed to this phase. Chemical analyses of the fluid which accumulates as result of trauma or burns in regions of the areas injured have shown that this fluid has essentially the same composition as the plasma of the blood, containing very few erythrocytes. The protein content is practically identical with that of plasma. In all these types of trauma, large quantities of plasma were lost and hemoconcentration was marked. Mann found similar results in experimental work on intestinal trauma. Blalock[3] states: "In summary, it is my impression that the local loss of fluid at the site of injury is sufficient in many instances of shock to account for at least part of the decline in blood volume and for some of the associated alterations. In other words, it is the most important initiating factor, not in all but in many instances of shock."

Those who hold to the local fluid loss theory as the most plausible explanation for the initiation of shock—and this is pretty generally the consensus of opinion at this time—stress the effect of the vicious cycle in its maintenance and aggravation. This vicious cycle has been well diagrammed by Moon.[11] Thus, to Moon, who favors the traumatic toxemia theory, the capillary is primarily damaged by an H-substance causing its dilatation and increased permeability with resulting loss in plasma protein, hemoconcentration, decreased blood volume, reduced cardiac output, arteriolar constriction, and capillary congestion. This condition is further aggravated by tissue anoxia which still further damages the capillary endothelium and ultimately results in the condition of irreversible shock, in which capillaries are irreparably injured and no amount of treatment is of any value.

Those who hold to the physical fluid loss theory recognize the vicious cycle initiated by plasma loss producing lowered osmotic pressure, increased capillary permeability with hemoconcentration and anoxia. So, regardless of which factor is of prime importance in initiating the shock, all are agreed that its fundamental manifestations are mediated through capillary damage.

CLASSIFICATION OF SHOCK

While there are many classifications of shock, some of them quite elaborate, it is sufficient for clinical purposes to divide the condition into (1) primary or neurogenic and (2) secondary or hematogenic.

Primary or neurogenic shock is synonymous with syncope or collapse. This may be brought about by emotions such as fright, or may occur during abdominal exploration in the region of the diaphragm. It occurs in spinal anesthesia. Goltz explained primary shock by demonstrating that a blow on the exposed mesentery of a frog caused reflex inhibition of the heart through the vagus and a lessening of vascular tone throughout the body, especially in the splanchic area. Primary, or neurogenic, shock is of short duration, and is characterized by peripheral vasodilatation, warm extremities and a slow pulse.

Secondary, or hematogenic, shock may follow primary or neurogenic shock immediately, but the onset of secondary shock is usually somewhat delayed and its clinical characteristics are quite different.

CLINICAL PICTURE

The clinical picture of well-developed secondary or hematogenic shock is familiar to all. The patient is pale, ashy gray; the extremities are cold; the pulse is rapid, thready; the blood pressure, which at first may be maintained fairly well, is characterized by decreased pulse pressure and a systolic pressure that falls more rapidly than the diastolic. The respirations are not labored. Muscular twitchings are common. Hipprocratic facies are frequent, and a stupor or delirium may be present. The diagnosis of hematogenic shock or peripheral circulatory failure is usually quite obvious. It is to be differentiated from acute failure of the heart. This commonly presents little difficulty. In acute failure of the heart, there is venous distention due to overfilling of the vascular bed, whereas shock is characterized by collapsed veins due to underfiilling of the vascular bed. Rapid and progressive enlargement of the liver, subcutaneous edema, pulmonary congestion evidenced by dyspnea, cough, râles at the lung bases, all point toward acute heart failure. The presence of a peritonitis, intestinal obstruction, or other etiologic factors of peripheral circulatory failure is readily contrasted with the manifestations of coronary thrombosis or pericardial fluid. The blood pressure alone is not a reliable indication in either condition.

The differentiation between peripheral circulatory failure due to hemorrhage and that due to trauma, burns, toxins, or any other cause is of more academic importance than of real clinical value. For, with the exception of the rapid exsanguination due to the injury of a very large vessel, the mechanism of death from hemorrhage is identical with that of death from other forms of shock, that is, "A progressive vasoconstrictive oligemic anoxia" (Harkins[8]). More will be said about the differentiation of shock due to hemorrhage and to other causes under the heading of treatment.

TREATMENT

It is axiomatic, obvious and trite to state the best treatment of traumatic shock and hemorrhage is their prevention. Under actual conditions of warfare, it has been found that a soldier is much more resistant to shock if he is well clothed in warm dry garments; if he is well fed with nourishing food containing an ample supply of vitamins, particularly vitamin C. Further, it is important to allay pain by the administration of opiates, by the prompt and efficient splinting of fractures, stop hemorrhage, prevent infection by the application of sterile dressings without chemical antiseptics, to immobilize wounds and to perform necessary procedures such as wound excision and debridement as soon as possible after the casualty occurs and before secondary shock supervenes.

Needless to say, operative procedures should be done deftly, promptly, and with no unnecessary handling of tissues.

Anesthesia.—Some authors express a preference for cyclopropane because it is administered with large quantities of oxygen. Others favor ether. There is some experimental evidence to indicate that sodium amytal is of value in minimizing shock.

Open pneumothorax should be closed by sutures or adhesive dressings. Tourniquets should be used only if bleeding cannot otherwise be controlled, and should be released each hour. Warm fluids, external heat, are of value, but excessive heat should not be used because of its tendency to aggravate capillary dilatation.

Vasoconstrictor drugs, such as epinephrine, ephedrin, caffeine, camphor, strychnine, coramine, benzedrine are absolutely contraindicated in secondary or hematogenic shock. They have some value in the treatment of primary or neurogenic shock. Pitressin may be found to be useful for its specific effect of causing a constriction of the capillaries and a decrease in their permeability.

Active Treatment.—The active treatment of secondary shock may be concisely stated as having two purposes: First, the replacement of fluid that has been lost and, second, the prevention of further fluid loss. The injured capillary, with its dilatation, increased permeability, leaking plasma, and concentration of cellular elements, is the direct object of therapeutic attack. Scudder's[13] excellent work in this field is a guide to efficient replacement and arrestive treatment. He stresses the necessity of considering not only the degree of hemoconcentration, but the degree of dehydration, and the level of plasma potassium. He finds that almost universally, in cases of shock and hemorrhage, there is a marked increase of the plasma potassium, and this factor he considers

of great importance in the vicious circle of shock. To Scudder the shock of Addisonian crisis, or that occurring in adrenalectomized animals, is essentially the same as shock occurring from other causes, and he feels this serves an important basis for the treatment of all conditions of shock.

The work of Gamble, Ross and Tisdal[6] on body fluids has shown that the chief base of blood and extracellular fluid is sodium, while potassium is the chief base of intracellular fluid. In shock states it is believed that intracellular potassium becomes extracellular potassium through adrenocortical failure, thus aggravating vasoconstriction and capillary damage.

Normal Values:

Cell Volume (Hematocrit):
Males—46 per cent, with a range of 42-50.
Females—average 41 per cent, with a range of 39-43.

Specific Gravity of Whole Blood:
Males—average 1.0566.
Females—average 1.0533.

Specific Gravity of Plasma:
Average for both sexes—1.0270. (The purpose of estimating plasma specific gravity is chiefly that it gives a rapid method of determining plasma protein.)

Plasma Protein: Approximately 70 grams of protein for each liter of plasma, variations between 5.9 and 6.9 grams per cent.

Plasma Potassium: Normally seventeen milligrams per hundred c.c.

Conversion Values:

Red Blood Count	Hemoglobin	Hematocrit Per Cent Cells	Specific Gravity of Blood
0	0	0	1.0300
1,000,000	20	10	1.0350
2,000,000	40	20	1.0400
3,000,000	60	30	1.0450
4,000,000	80	40	1.0500
5,000,000	100	50	1.0550
6,000,000	120	60	1.0600

Characteristic findings in specific conditions:

Hemorrhage.—Early following hemorrhage of moderate or considerable degree, there is usually hemo dilution, characterized by lowered hematocrit (cell volume) reading, lowered specific gravity of whole blood and plasma, lowered hemoglobin, and lowered red blood count.

Simple dehydration.—This represents actual acute water loss. It is found in conditions in which there are excessive vomiting, severe diarrhea, diminished fluid intake.

There are found hemoconcentration, increased specific gravity of the blood and plasma, and increased red cell and hemoglobin determination.

Shock.—This represents varying degrees of water, protein, and whole blood loss, depending upon the causative factor. There is definite hemoconcentration, as represented by the increased hematocrit readings, increased hemoglobin and red blood cell determinations, and there is decreased plasma protein. In most, if not all, of these conditions as emphasized by Scudder, there is a definite increase in the plasma potassium whose normal value is 17 milligrams per hundred c.c. of plasma.

In simple dehydration which has not progressed to the extent of true shock with plasma and protein loss, the administration of crystalloids, such as glucose in normal saline, is logical and effective. The progress of the patient under these conditions should be carefully checked by further determinations of the plasma protein, to make sure that the crystalloid solutions thus introduced are not washing out the needed plasma protein through damaged capillary endothelium.

It cannot be too strongly emphasized that hypertonic solutions of crystalloids in themselves are considered, by most observers, to be absolutely contraindicated in the treatment of full-blown secondary shock. Scudder, however, believes that the use of five per cent sodium chloride solution is indicated in the treatment of shock as an adjunct to the use of blood plasma, or serum, for the reason that it serves to counteract the effect of excessive plasma potassium, which factor he feels is of importance as a positive H-substance in aggravating capillary damage. His findings have not been widely confirmed, but his published results in the use of this therapy seem excellent.

In peripheral circulatory failure, obviously due to hemorrhage, the use of whole blood, either fresh or preserved, would seem to be the method of choice. However, even in hemorrhage, it is rarely the loss of blood itself that causes death, but the secondary shock syndrome which is responsible for the fatality. Therefore, with the hemorrhage arrested, plasma or serum are quite suitable.

Secondary Shock.—In all instances of secondary shock, regardless of their origin, plasma or serum is the ideal method of treatment. This is directed at restoring the normal values of plasma protein, which is responsible for the osmotic pressure which in turn maintains normal blood volume. There has been much controversy in the past over the relative merits of plasma and serum. Those who oppose plasma contend that the introduction of citrate to prevent clotting, together with the fibrin veil, are objectionable features. Those who object to serum state that its administration is more apt to be accompanied by reactions. These reactions are explained on the basis of the production of vasoconstrictor and vasodilator substances during the mechanism of clotting which removes fibrin. Volume for volume, plasma and serum are of approximately equal value in restoring osmotic pressure. Both plasma and serum may be stored in sterile containers at room temperature indefinitely. They may both be dried by any one of several desiccating processes and stored, transported, and used with the addition of distilled water or normal salt upon an instant's notice. The advantages of plasma and serum administration are many and obvious. Pooled plasma or serum is used without typing, because the isoagglutinins are thus neutralized.

COMMENT

The most common mistake made in treatment of these patients is failure to give sufficient plasma or serum. As a rough rule of thumb, it may be stated that 100 c.c. of plasma are required for every point of hematocrit reading above 45 per cent. But, there are no cook-book rules whereby treatment may be reduced to mathematical precision. Careful clinical observation of the patient, repeated check on hematocrit, hemoglobin, specific gravity, plasma protein are all essential if success is to be obtained. In shock whole blood is contraindicated because it adds more cellular elements to an already congested capillary bed. However, British authorities state that when three or more pints of plasma are required, one in three should be whole blood.

The second objective of treatment, that is, the restoration of the damaged capillary endothelium to a normal state in order to prevent further fluid loss into the tissue spaces, is the most difficult to achieve. The two chief remedies at present available for this purpose are oxygen and adrenocortical extract.

Oxygen should be given, in 100 per cent concentration, by the BLB mask. In this manner, much may be done to prevent anoxia which is one of the important sustaining factors in capillary damage. It may be continuously administered in this way for 48 hours without danger. Adrenocortical extract in doses of from ten to twenty c.c. in the form of Eschatin intravenously or intramuscularly seems indicated both from the standpoint of clinical results and from theoretical considerations inasmuch as this cortical extract is believed to decrease capillary permeability and also to decrease hyperpotassemia. Scudder is particularly enthusiastic over the use of large doses of eschatin intravenously, together with five per cent sodium chloride as an adjunct to plasma or serum, but he emphasizes the necessity of accurate laboratory control for all of these measures.

Hyland[16] states that the plasma albumin is responsible for 80 per cent of the osmotic pressure of the plasma protein, and that its preparation in a comparatively pure form by precipitation of the globulin by ammonium sulphate may offer in the future a more accurate means of treating the hypoproteinemia due to shock. Other investigators have studied the possible use of bovine albumin, but their results are as yet too contradictory to be reliable for clinical use.

IN CONCLUSION

Traumatic or wound shock and the syndrome of shock or collapse consequent upon hemorrhage are but two manifestations of peripheral circulatory failure, the basic factor of which is a damaged capillary endothelium with dilatation and abnormal permeability accounting for all of the symptoms involved. Treatment should be directed toward prevention as far as that is possible; toward early replacement of lost blood volume by the essential proteins, and toward the restoration of the damaged capillary endothelium to as normal a state as possible.

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DERMATOSES: THEIR LOCAL TREATMENT WITH SULFATHIAZOLE AND SULFADIAZINE*

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NEARLY all diseases under my observation, where a pyogenic element could be suspected, were approached on the assumption that most skin diseases present a symbiosis of various staphylococcus and streptococcus cultures, besides the essential fundamental characteristics pertaining to each disease. This having been undertaken during the last year, prior to this date, sulfathiazole would be the first to be tried out. Stimulated by various inciting reports of impetigo treated with the sulfa drugs, the beneficial influence on this disease group was first rapidly confirmed.

* Read before the Section on Dermatology and Syphilology, at the Seventy-first Annual Session of the California Medical Association, Del Monte, May 3-6, 1942.

Current literature on the topical use of sulfathiazole is still scant. However, L. Keeney,[1] et al., treated sixty-nine patients with sufathiazole incorporated in salves, five per cent. He had more or less striking results, particularly in secondarily infected eczema, seborrheic dermatitis, impetigo, acne vulgaris, mercurial folliculitis and furunculosis. They noticed no toxic effect, and, even when the salve was applied over half the body, the blood concentration varied roughly from 2.0 to 3.5 milligrams per 100 c.c. of blood. In limited areas no traceable concentration could be detected. The physical well-being improved quickly after the application, from immediately afterwards until from one to two weeks.

H. M. Robinson and H. M. Robinson, Jr.,[2] observe the same dramatic improvement, but take the exception that it is valueless in epidermophytosis, contact dermatitis, as well as in other dermatoses.

For the rest, extensive reports deal with the oral administration in various dermatoses. This article deals only with the topical applications. The oral administration of sulfathiazole, et al., being left out entirely, has some bearing on oral administration of sulfathiazole only as far as sensitivity reactions go. Since some of my patients did come under observation where previous oral sulfa drug medication had resulted in skin reactions and (by omission of information), subsequent applications of sulfa drugs were given, severe local reactions were invariably seen; the physicians in charge being without blame for these mistakes.

AUTHOR'S OBSERVATIONS

After a more cautious approach, I expanded enthusiastically to various types of diseases connected with mixed staphylococcus-streptococcus infection as a primary causative factor, or, secondly, as an additional acquired factor. All together about three hundred cases have been approached this way and only by external medication—no oral medication. Sulfathiazole was used first, and, during the last two months, sulfadiazine. The drugs were incorporated in salves, powders and paints; in the same way any other ingredient would have been incorporated in the disease to be treated. For example: salves for psoriasis, powder or paint for intertriginous eczema and so forth. The concentration of sulfathiazole in salves and lotions was kept constantly at three per cent, and in powders, five per cent; for sulfadiazine, three per cent, and in exceptional cases, four per cent in salves and powders. Both were applied twice a day with specific instructions for the patient to clean the skin with oil before applying.

DISEASES UNDER TREATMENT

The following is a list of the diseases treated: Impetigo, Folliculitis, Sycosis Barbae, Dermatitis Venenata, Poison Oak, Acne Vulgaris, Cystic Acne, Acne Rosacea, Boils, Abscesses, Stasis Dermatitis, Neurodermatitis, Intertriginous Eczema, Herpes simplex, Herpes zoster, x-ray ulcer, Epidermaphytosis, Seborrheich dermatitis, Perleche, Paronychia, Monilia infection, Psoriasis, Lichen Planus, Lupus Erythematosus, Pemphigus, Darrier's Disease.

Since it was felt that here was an enormous field opening up, I need not ask excuse for having employed it in so widely different diseases as impetigo and infectious eczema up to such impossible probabilities as psoriasis. In the latter it was assumed that sulfathiazole might be a photosensitizer, and that exposure to ultra violet light at the same time as the applications were given would enhance the effect of ultra violet light. (This, however, did not materialize.)

I reserved the investigation for my private cases. A certain number which were treated at Stanford Medical School, Dermatological Clinic, responded quite well, although they are not included in these tabulations.

Because the applications were used over a limited area, no blood estimates were taken, since only extensive use of both drugs gave traceable blood concentrations.

TABLE 1.—*Local Treatment of Dermatoses with Sulfadiazine and Sulfathiazole*

Disease	*Cases*	*Average Days Healing Time*	*Sensitivity*
Impetigo	15	8	2
Folliculitis	54	7	
Sycosis Barba	6	8	
Dermatitis Venenata	51	11	
Poison Oak	*	*	
Acne Vulgaris	35[2]	7 to 14	2
Cystic Acne	9[3]	10	
Acne Rosacea	6	7 to 14	1
Boils, Abscesses	15		
Stasis Dermatitis	15	15	
Neurodermatitis	9	8	1
Intertriginous Eczema	12	6	
Herpes Simplex	*	*	
Herpes Zoster	2	prompt	
X-ray ulcer	3	prompt	1
Epidermophytosis	15	prompt	1
Seborrheic dermatitis	30	7 to 14	1
Perleche, etc. (Paronychia, Moniliasis)			
Ulcers	*	*	
Psoriasis	4[1]		
Blistering Burns	*	*	
Lichen Planus	2[1]		
Lupus Erythematosus	2[1]		
Pemphigus	1		
Darrier's Disease	1		

*Inconclusive—10% or less.
[1] No Response. Response: 75-80%.
[2] Improvement 50%. Did not Return: 28-8%.
[3] Improvement 30%.

COMMENT

It will be seen that some of the diseases offered for treatment with sulfathiazole and sulfadiazine responded well, and in a dramatic and encouraging way. Obviously, it is difficult or impossible to classify in detail the conditions and concommittant situations in this treatment group. Coöperation, comprehension and willingness to carry out the instructions given are all deciding factors; and, last but not least, comes the cutaneous sensations which will aggravate and impede healing ad

infinitum unless the treated parts are protected in some or other way. I beg, therefore, that these data not be interpreted too literally, but with a broad understanding. Taken as a whole, the treatment was easy to carry out ambulatory.

I can fully subscribe to the optimistic view regarding *impetigo* treated with sulfathiazole. My average of eight days could easily be improved to a much shorter period depending upon what type of case was to be treated. Usually the general condition and hygiene (management by the patient) were all-important factors as well.

As would be expected, *folliculitis and sycosis barba* responded dramatically. An average of seven days for the prevention of new lesions to appear as compared with the weeks', and often months' duration of such lesions to other measures, makes sulfathiazole a drug of choice. Certain cases of sycosis barba will respond as dramatically as impetigo if other measures are considered as well. One recalcitrant case had to be approached by other means. I believe the régime and handling, correct management of these severe cases is all important as well, besides the applications of sulfathiazole. Naturally, there will be cases which do not respond because of voluntary or involuntary mechanical friction, apposition of skin folds, discharge from sinuses, and so forth, which will handicap the quick cure.

Stasis dermatitis, especially where there is any amount of secondary infection, healed up in an average of fifteen days, in sharp contrast to the month-long treatment which any other régime will require. In this series is included weeping, raw forms, excluding outright ulcers. A fifty-five year old gentleman with elephantiasis-like swelling of the left leg and varicosities will long be remembered. The leg was secondarily infected and enormous verrucuos proliferations had deformed the entire leg and foot completely and incapacitated the patient, who was bedridden. In two months, during which three per cent sulfathiazole in cold cream was applied (plus bed rest), the leg resumed its gradual normal proportions, and the patient seemed as impressed as the attending nurses and myself were. The beneficial effect of the sulfathiazole applications in this form of dermatitis can be warmly recommended, and could be employed as salves, wet-packs or powders, depending upon the amount of weeping and ulceration which would follow. The lack of response in severe cases was mostly caused by other elements not pertaining to the pyogenic elements.

Dermatitis venenata, counting all types from the more severe to the lightest ones, healed up in an average of eleven days. At first thought this would not seem very striking as compared with other methods. Naturally, there are some cases which would heal up just as fast or faster under ordinary methods like mild, antiseptic wet-packs. However, long-standing and severe industrial cases, and the severe secondary infection often associated with these cases respond extremely favorably. These patients did not offer great incidence of sensitivity to sulfa drugs.

Certain types of *seborrheic dermatitis,* next, healed up so dramatically that I almost resent that an average of seven days for the common seborrheic dermatitis, including seborrheic dermatitis of the eyelids, may sound rather optimistic. In the judgment, I have not included heavy, chronic cases where multiple elements such as neurodermatitis, impaired nutrition and circulation, mechanical factors and so forth, played in.

Nevertheless, seborrheic dermatitis of the eyelids is another field with improved aspects. From oral communications, I gathered that cases which were always referred to dermatologists, now by contrast are treated with more confidence by the opthalmologist. Previously, a rigid and severe régime, wet packs, and possible hospitalization were required, whereas, now, most cases will respond to the sulfathiazole and sulfadiazine treatment almost "overnight."

Contrary to other reports, I feel that seborrheic dermatitis of the scalp is rather irresponsive, particularly combined with "neurodermatitis" in the nape of the neck. This condition requires more severe and specific antiseborrheic measures in addition to the sulfathiazole treatment, if used at all.

Acne cases will naturally vary enormously in response because of the patient's habitus, anatomy of the skin and many other factors. So, when I say that the improvement was definite after twenty-three days, it has to be taken for granted that this only means an initial or adjuvant measure in the acne régime. Two or three cases would show a debatable improvement and, for the rest, they all showed some response. If this could be referred to other measures was not always easy to decide. It is a matter of fact that the full understanding of this complex disease will require a number of other approaches as well. I should say the greatest value of sulfathiazole is the intermittent use with other known topical applications in general measure. It can be safely stated that a few "not quite so good" responses received the finishing touch by the sulfa drugs. Peculiarly enough, sensitivity cases were most frequent in these series.

Furunculosis and abscess formation treated by local applications alone seemed to offer no definite advantage over other methods or applications in as far as the cure of the furuncles or abscesses go; but I do feel that it offers advantage in preventing spread of follicular lesions or formations of new furuncles in the surroundings. As a matter of fact, I believe the oral applications would be the method of choice.

Contrary to other reports, I feel that certain forms of *epidermophytosis* offer a field where sulfathiazole is of decided value, such as the secondarily-infected type, where there is weeping, eczematous and inflammatory changes, as found both in the feet, skin folds and free body surfaces (on this last site with the least effect). For the skilled skin specialist it will be to judge when the

time comes to discard the sulfathiazole and take advantage of fungicides. Misjudging the interplay of many conditions present at the same time, the average physician usually overtreats an epidermophytosis with strong fungicides and will have concomittant, irritative phenomena with secondary infection dominating the picture. Then sulfathiazole, employed at the right time, will outdo any previous methods. It seems safe to say that sulfathiazole and sulfadiazine should not be considered to be fungicides. In the groins and other skin folds, as in *pruritus ani and intertriginous eczema,* the soggy appearance of the skin, together with a certain amount of moisture and particularly weeping surfaces, are strong indications for an initial approach with sulfathiazole usually employed thinly in ointments. This seemed better than when incorporated in lotions or powders.

Last, but not least, I may add the use in an ointment base in *paronychia,* which is usually recalcitrant in all hitherto known methods. No case failed to respond immediately. I felt this disorder now could be approached with greater confidence, provided the usual preventative measures were taken, also considering the coöperation of the patient. This included temporarily staying away from moisture, handling pastry, etc.

In *hemangiomas and warts* treated with carbon dioxide application, where blister formation will usually invite infection, the ulcers progressed naturally and quickly to healing. Any infected hemangioma will tolerate sulfathiazole applications in the form of salve on a gauze pad very well. The comfort to the child, and the lessened danger of septicimia, are weighty considerations, not to mention the easy handling of clean surfaces.

Other diseases, like herpes simplex, acne rosacea, poison oak dermatitis and pemphigus, will often respond with varying results. Here, also, many individual factors will play in. I feel, however, that pemphigus should be approached by topical applications with sulfathiazole or sulfadiazine; but having seen only one case respond favorably, I would not pass judgment. It would be invaluable as a protection against secondary invaders, especially in the latent stages with extensive, denuded, raw areas.

I mentioned the fact that sulfadiazine has been used by me the last two months only. I prefer not going into details, since it will complicate the picture and shall limit myself to the statement that there seems to be some advantage in using sulfadiazine, although instances could be quoted where sulfathiazole was better than sulfadiazine. On the other hand, I feel very strongly that the sensitivity reactions are less apt to occur with sulfadiazine. Of the whole series, ten cases of sensitivity to both sulfadiazine and sulfathiazole occurred. Without exception the sensitivity or dermatitis venenata which developed receded immediately on discontinuing the drug.

SUMMARY

Sulfathiazole and sulfadiazine offer themselves for a logical and discriminate topical application in dermatology, and have reduced the treatment period for primarily and secondarily infected skin diseases, vesicular and herpetic lesions, from one-half to one-third of the usual time in responsive cases. They usually prevent infections if applied early, causing nearly involution. An initial improvement, only, was observed where two or more conditions prevailed.

Sensitivity reactions were found to be relatively high (3.3 per cent), and parallel to the sensitivity reactions found in oral administration. One exception, where prolonged oral administration was tolerated, simultaneous local application gave severe sensitivity reaction. They present a decided danger, where occasionally an already critical and extensive dermatosis may be seriously aggravated.

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ANEURYSM OF THE RIGHT PULMONARY ARTERY

WITH RUPTURE INTO BRONCHUS; AND A PATENT DUCTUS ARTERIOSUS. REPORT OF CASE

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ANEURYSM of the trunk of the main branches of the pulmonary artery is rare. All investigators agree upon the rarity of this condition, as is established by post-mortem statistics from various sources. Jennis,[1] in 37,757 consecutive autopsies, found 1,671 aneurysms, none of which involved the pulmonary artery. According to Boyd and McGavack,[2] up to 1939 there were 139 cases reported, 30 of these with an antemortem diagnosis. Since their report, only four additional cases have been reported—Plenczner,[3] Duperie and de Lochand,[4] Reiner,[5] and Breslin, Solway and Eisen.[6] This case report makes a total of 144; 31 in which an antemortem diagnosis was made and proved by autopsy—present time June, 1942. The increasing number of antemortem diagnoses is due to progressive improvement in roentgenologic methods.

Age and Sex Incidence.—Sex has apparently little significance, since a few more cases were found in the female than in the male. Most writers agree as to the age incidence and Costa[7] has compiled the statistics in table form. (Table 1.)

TABLE 1.—*Incidence According to Age (Costa)*

Age	Aneurysm of aorta	Aneurysm of pulmonary artery: With malformation	Aneurysm of pulmonary artery: With infection	Total
	Per Cent	Per Cent	Per Cent	Per Cent
0-30 years.....	12.0	28.5	9.5	38.0
31-50 years.....	62.0	15.8	23.8	39.6
Over 50 years.....	25.0	3.1	19.0	22.1

Of the cases, 38 per cent occurred under 30 years of age. This is in distinct contrast with aortic aneurysms in which only 12 per cent occurred under 30 years of age. Consideration of the table shows that in the majority of patients under 30 years of age aneurysms of the pulmonary artery are coincident with malformations, which explains the difference in age incidence between cases of aneurysm of the aorta and pulmonary artery. After the age of 50, there is no appreciable variation in age incidence between the two lesions. Accordingly, the analysis of age and sex incidence suggests that different etiologic functional and anatomic factors are operative in the two types of aneurysm.

ETIOLOGY

Boyd and McGavack conclude that increased pressure within the pulmonary circulation, plus arteriosclerosis are the chief etiological factors except where infection—subacute bacterial endocarditis—supervenes. Syphilis plays a less important part, contrary to the view of Warthin.[8] Rheumatic fever has been an antecedent factor. Trauma[9] also plays a rôle. Costa finds that in 46.5 per cent of all cases, some evidence of congenital defects can be found, the most frequent being a persistent patent ductus arteriosus (20 per cent).

Morphology.—The morphology has been well discussed by Costa, who observed that the trunk of the artery was the site of the aneurysm in 85 per cent of his cases. More frequently the condition was found nearer the valves than the bifurcation into the two main branches. Aneurysms are rarely found in the branches of the pulmonary artery (15 per cent), and less frequently in the right branch than in the left. Aneurysm formation is usually single, but multiple formation has also been reported. The shape is usually fusiform, but succiform aneurysms have also been reported. Dissecting aneurysms are rare, according to Neuburger.[10] The size varies from that of a nut to that of an orange, according to Lissauer[11] and Henschen;[12] while Perry[13] and others have reported very large aneurysms. The sac of the aneurysm is usually filled with lamellated clotted blood, which sometimes occludes the entire lumen of the artery. The wall of an aneurysm of the pulmonary artery is usually much thinner than that of an aneurysm of the aorta of the same size. The media and intima of the pulmonary artery offer little resistance to the blood pressure and are quickly destroyed.

CLINICAL FEATURES

The symptomatology of pulmonary aneurysm is by no means uniform, depending largely upon the coëxisting congenital anomalies. Boyd and McGavack, and Mason[14] enumerate dyspnoea, especially on exertion; cough, either dry or with sputum which may be blood-tinged; palpitation; precordial or substernal distress; sense of fullness in the chest and edema of the extremities. All or any of these may be encountered.

In the 30 cases of pulmonary aneurysm diagnosed clinically up to the present, the following were the most commonly observed physical signs: Prominence of the left side of the chest, especially in the second and third interspaces; with this were associated pulsation, occasionally a systolic thrill, impairment of resonance, and a harsh, sawing, systolic murmur in the same area. Groedel[15] states that these findings are inversely proportional to the amount of thrombosis in the aneurysm. Right-sided cardiac hypertrophy and dilatation may at times be found, but in the left ventricle are almost invariably absent. The electrocardiographic tracings may show right axis deviation. The roentgen ray is unquestionably of chief assistance in establishing a clinical diagnosis. Films should be taken in all standard positions. Fluoroscopic study is of extreme importance. The diagnosis is based on the marked prominence of the pulmonic arc on the left border of the cardiac silhouette which pulsates synchronously with the aorta when the latter is visible, or "see-saws" with the left ventricle, and which tends to obliterate the normal translucency of the "aortic window." In the presence of thrombosis of the aneurysm, pulsation may be diminished or absent. The differential diagnosis has been discussed by Boyd and McGavack, and Mason. Exitus by sudden death because of rupture of the aneurysm into the pericardium, or pleural cavity, or into the bronchus, occurs in approximately half the cases. The remainder die of congestive heart failure, or septic endocarditis.

REPORT OF CASE

Mrs. B. V. S., a 21-year-old housewife, was first seen by me on July 23, 1941, because of a sudden moderately severe hemoptysis. She had a letter from her attending physician in Iowa stating that she was subject to these hemorrhages, and that a tentative diagnosis had been made by the State University of Iowa, of a possible aneurysm of the right pulmonary artery with a patent ductus arteriosus.

Past History.—Her past history was obtained from the records of the State University of Iowa: When she was six years old, she was told that she had some form of heart disease. She was seen in the cardiac clinic and was told that she had a leakage of the heart. When she was eight years old she remembered that all her joints were hurting and swollen. She does not remember how long, but knows it lasted at least three weeks. All her joints were involved and she could not stand to have blankets on her limbs. She had always played hard with other children. She had been slightly short of breath in the last few years, but, while one flight of stairs did not bring this on, two would. She had a crowding and dull pain around her heart, and this would also occur occasionally when she would lie down. The patient stated that she had pneumonia in June and September of 1937. The second attack was accompanied with fever, chills, cough and hemoptysis. She was in bed for four weeks the first time. She did not regain her strength after the first attack, and felt feverish and chilly between the two spells of pneumonia.

Since these spells of pneumonia she has had repeated spells of hemoptysis, chills, and fever, pain in the right

base anteriorly, with loss of weight and appetite (140 pounds last year, 122 at present. Maximum weight, 140 pounds). The blood in the sputum varied from a speck to 1 or 2 ounces, and it was usually dark. She might have this 2 or 3 times a week, and then none for 2 or 3 months. She was in Sunnyslope Sanatorium for ten months in 1937 and 1938, and the final diagnosis was negative for tubuerculosis, negative sputum, "spot on right lung." She has had chest plates regularly, the last one being last summer, 1940, and they showed a healed spot. In the last year she has noticed increasing fatigue. The patient stated that her mother had often said that she was a blue baby.

Physical examination in November, 1940, revealed a well-developed, well-nourished, white female who did not appear to be ill. The skin was negative. There was no cyanosis. There was no clubbing of the fingernails and there was no edema. The head was negative. There were bilateral tonsillar tags. The teeth were in good repair. The left shoulder was carried somewhat lower than the right. There was no lag of expansion, and no change in the vibratory phenomena. The breath sounds were unchanged. There were no râles, rubs, or ronchi. The percussion note was normal. There was no cardiac enlargement. There was a long thrill palpable over the base of the heart. There was a long diminuendo murmur, starting just before the first sound and ending in diastole heard best at the left second and third interspace near the sternum, and transmitted down to the left toward the apex. The blood pressure was 125/70. The pulse was 80 and regular. There was a capillary pulse present in the fingernail beds. The abdomen was scaphoid, and there were no masses, tenderness, spasm, or herniae. The aorta was readily accessible. Pelvic examination was negative. Neurological examination was negative. Urine examinations were negative. The Hb was 14 grams, RBC 5.0 million, and WBC was 10,000, with a normal differential. The tuberculin test was negative. An electrocardiogram was negative.

bases. Acid-fast smears were negative. A guinea pig was inoculated and found negative. The patient was bronchoscoped. There was a smooth, rounded swelling which appeared to be present in the region of the lower right middle lobe above the septum. No biopsy was done. The blood Wassermann was negative. The material from the bronchoscopic aspiration revealed no growths when cultured.

Impression.—Congenital heart disease, probably patent ductus arteriosis, and probably benign tumor of the lung.

The patient was seen in the Medical Clinic, March 12, 1941. Since her discharge from the hospital in December, 1940, she has felt well and has been working. She has had two hemoptyses, but no other symptoms. Physical examination disclosed no change from the findings of her hospital admission previously. X-ray of the chest also showed no appreciable change in the shadow. The x-ray department now felt that the shadow in the right lung field was most probably an aneurysm of the right pulmonary artery; and since she is also thought to have a patent ductus arteriosus, it is reasonable to assume that the aneurysm is also congenital.

Physical Examination.—Physical examination (July, 1941), revealed a pale, well-developed and well-nourished white female, lying on the bed with her head over the side and blood streaming from her nostrils and mouth. After the hemorrhage subsided, her pulse was 120 and blood pressure 118/80. The heart was not enlarged. No thrill was palpable; but there was a loud, long continuous, systolic murmur, heard best at the second left intercostal space near the sternum. There was dullness to percussion over the right base posteriorly with numerous coarse-to-fine râles. A blood count made several days later showed: Hb 55 per cent, RBC 2,620,000 and WBC 10 000, with a normal differential. The urine was normal and the electrocardiogram was negative. The chest cleared up and her blood was restored to normal with the conventional methods of treatment. She was relatively symptom-free, except for an occasional hemoptysis. Then

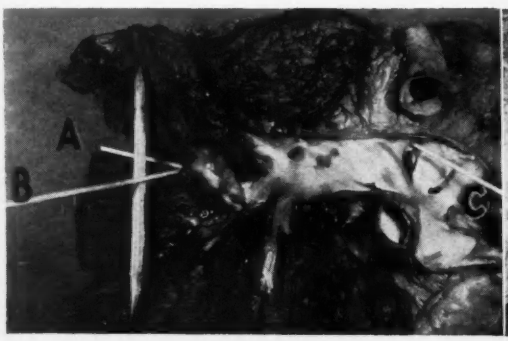

Fig. 1.—*Anterior View:* A, aneurysmal sac; B, opening into bronchus; C, patent ductus arteriosus.

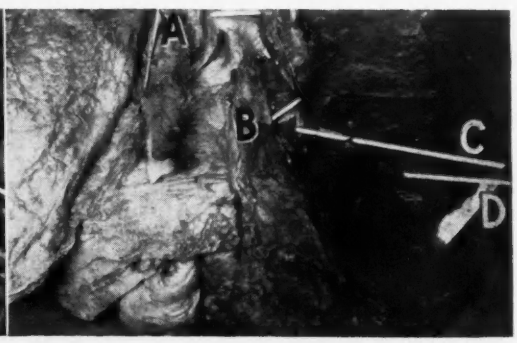

Fig. 2.—*Posterior View:* A, bifurcation trachea; B, right bronchus; C, communication between aneurysm and branch of right bronchus; D, aneurysmal sac; the darkened middle lobe is filled with blood.

A chest plate showed a bronchosinusitis chest. In the right base there was a shadow of increased density, sharply bordered, measuring 3 cm. in diameter. A lateral view showed this to be located in the midportion of the lung immediately in front of the spine. It was the impression of the Department of Roentgenology that this represented a benign tumor of the lung. The contour of the heart was somewhat suggestive of rheumatic heart disease. A left lateral esophagram showed no evidence of left auricular enlargement. Lung mapping was done, and showed a very mild cylindrical bronchiectasis in both

she had another hemoptysis on November 21, 1941, which was a little more severe, and from then to her fatal hemorrhage on June 1, 1942, she had felt better than ever before.

During the time while under my care her complaints were: cough, productive-fresh and dark blood from time to time; dyspnea only on exertion; sense of fullness in the right chest, especially when lying down, and occasionally a dull pain around her heart. Between her attacks of hemoptysis she felt very well.

Autopsy.—Both pleural cavities were almost obliterated by dense fibrous adhesions. The heart and lungs were removed en toto. The pericardial sac contained about 40 cc. of clear yellow fluid. The heart was pale, not enlarged, the right ventricular wall measuring 7 mm and the left 20 mm. The tricuspid, pulmonary, bicuspid and aortic valves showed no changes. The aorta was normal and the ductus arteriosus was patent. The pulmonary artery was 8 cm. in its main portion, 4 cm. on the right, and 3 cm. on the left, and 7.5 cm. from its bifurcation on the right side there was a saccular enlargement 3 x 4 cm. The sac was empty, the wall was smooth and in the right upper quadrant of the sac the wall was thin, wrinkled, with a valve-like structure which interposed between the aneurysm and the branch of the right bronchus. The aneurysm opened into a smooth, lined saccular cavity measuring 1.5 cm. in diameter. This cavity opened into a branch of the right bronchus 5.5 cm. below the bifurcation of the trachea. The left lung, and the upper and lower lobes of the right lung were pale. The middle lobe was filled with fresh blood.

COMMENT AND SUMMARY

A congenital aneurysm confined to the right branch of the pulmonary artery, with rupture into the bronchus and a patent ductus arteriosus, is reported. An antemortem diagnosis, which I confirmed by autopsy, was made by the x-ray department of the State University of Iowa. This case report makes a total of 31 cases diagnosed antemortem, and a total of 144 cases reported to the present time. The patient had relatively few symptoms and signs. There was no elevation of blood pressure, no prominence of the left side of the chest, no right-sided cardiac hypertrophy and no electrocardiographic changes. The roentgen ray was unquestionably of chief assistance in establishing the diagnosis. The occurrence of these aneurysms is rare, but it is important to emphasize their consideration in the differential diagnosis of hemoptysis.*

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* Author wishes to express his appreciation to Doctors R. H. Lage, Frank Russell and Ben Walker for their help with this report.

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NASAL ALLERGY: THE OTOLARYNGOLOGISTS' PROBLEM

IN RELATION TO SOUTHERN CALIFORNIA DISTRICTS

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THE otolaryngologists' nasal problem in Southern California, and in other similar climatic areas in the United States, is unique. In addition to the usual naso-sinusal problems, we have to contend with an unremitting nasal affliction which results in symptoms throughout the entire respiratory system, and affects at least fifty per cent of the patients referred to the otolaryngologist with chronic "catarrhal" ear, nose, and throat complaints. These patients have been diagnosed as suffering from "constant colds," "catarrh," "chronic sinusitis," "chronic streptococcic sore throat," or "bronchitis." In reality, the fundamental etiology, in most of these cases, is the perennial allergy characteristic of Southern California. The basic allergy in the majority of these cases is pollen sensitivity. It is not within the scope of this paper to consider the otolaryngological aspects of food, house dust, epidermal or fungous sensitivities.

Adequately treated naso-sinusal disease of bacterial origin usually can be cleared up readily. When the history, clinical picture, and the subsequent course is more or less befogged, and the "sinus" infection occurs again and again, the "cold" continues despite competent treatment, the Eustachian tubes block intermittently, the sore throat recurs without new bacterial infection, or the cough persists, an unrecognized hidden allergy must be predicated.

OBSERVATION IN SOUTHERN CALIFORNIA: SYMPTOMS

A minimum of fifty per cent of the patients in Southern California with perennial "catarrhal" complaints attributable to the nose and

sinuses do not give clear-cut histories. Their main complaint is nasal obstruction, which may be partial or complete, bilateral or unilateral. Usually the obstruction is unilateral, with a shift from side to side about every four hours. Cough is also a common symptom. The cough may be nocturnal and accompanied by champing and grinding of the teeth and snoring. There is almost always a morning cough, with the production of clear tenacious mucous and the freeing from the throat of a lump of mucous, mucopus, or inspissated "dark-brown" crusts. A dry sore throat is usually present, which disappears as the morning progresses. Sneezing, when present, is also an early morning feature. There may be some sero-mucoid secretion blown from the nose during the day, but the amount is larger on first arising. The patient sometimes complains of a pressure type of headache across the bridge of the nose, and extending over the cheeks, and with a sense of fullness behind the eye. The headache may also involve the frontal area, especially over the glabella. Very often the individual will mention that he feels mentally dull, is unable to comprehend conversation or written text readily, and that his eyes tire easily. These symptoms of headache, pressure, and mental clouding, as well as the complaints mentioned before, are usually relieved when adequate nasal ventilation is established by topical or internal administration of sympathomimetic drugs.

The affliction, caused by the perennial Southern California pollens, is constant throughout the year. It is infrequent that the patient will give a history showing regular seasonal exacerbations. When intermittent flare-ups of the habitual symptoms do occur, the patient will declare that he "caught a cold" at those particular times, and usually will not associate the increase in symptoms with his inveterate grievances. The more or less mild, perpetual naso-sinusal-pharyngeal-bronchial effects continue day-in and day-out, without reference to weather or to occupation.

PHYSICAL APPEARANCES

Examination of these cases will sometimes show the classic bluish-white congestion of an allergic mucosal lesion. The oedema may be bilateral involving the septal, middle turbinal, and especially the inferior turbinal mucosa. Usually only one side is affected at the time examined, and later the nasal mucosa in the other airway will be swollen. A more advanced stage is occasionally found in which the nasal mucosa has become more pearly, the involvement is bilaterial, and the swelling recedes very little, except with the very strongest of con-

CHART I POLLEN SEASONS

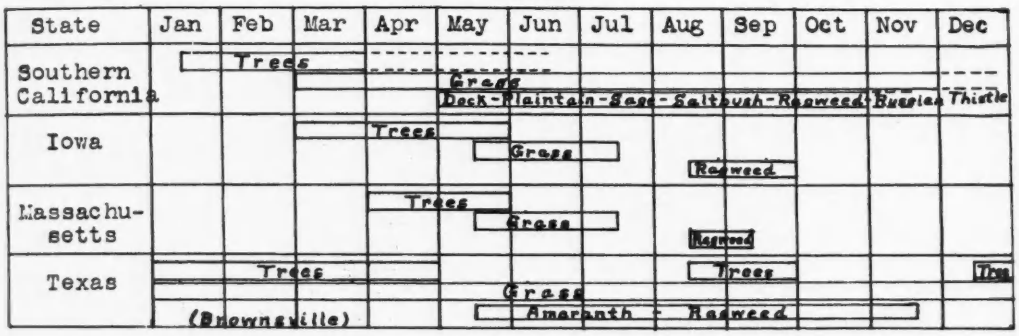
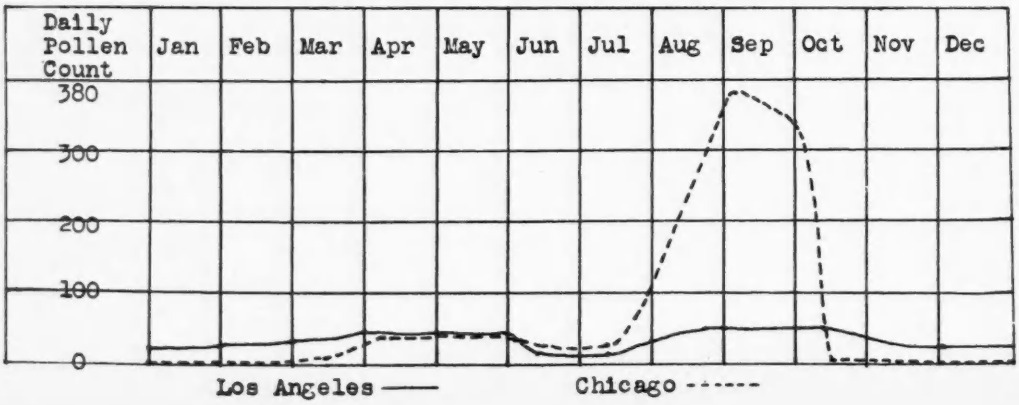


CHART II DAILY COMPARATIVE SLIDE COUNTS OF POLLENS - 1940



stricting drugs. The pharyngeal wall commonly will show lateral bands and a studding of lymphoid follicles on the posterior surface against a pale mucosa, which extends downward to the hypo-pharynx.

OTHER EXAMINATIONS

Transillumination, in the absence of secondary or prior sinusitis, is clear and equal, and of little value except in searching for secondary infection.

X-ray examination will usually show a uniform thickening of the sinus mucosa, especially in the antra and ethmoids. The lungs will show a thickening of the bronchial-tree shadows.

Smear examination of the nasal secretions rarely shows a sufficient number of eosinophiles to be of definite value. If a positive eosinophilia is demonstrated, it may be taken as confirmation of the indicated allergy. However, a negative smear, or even repeated negative smears, does not annul the allergic diagnosis. Secondary infection, although slight, will invalidate the eosinophile test.

DIAGNOSIS

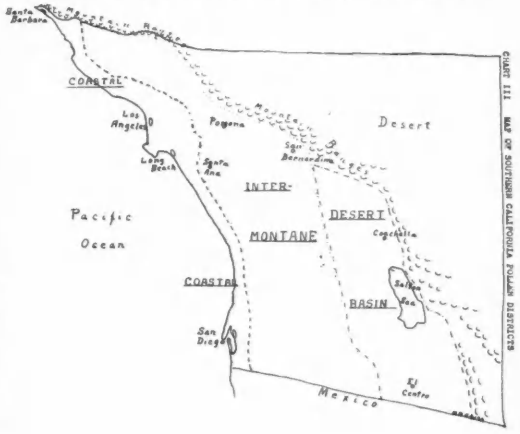
In Southern California, and similar climatic areas in the United States, allergy of the respiratory tract may simulate most of the signs and symptoms of acute or chronic infection of the nose, sinuses, pharynges, or bronchi. The diagnosis of the allergic etiology is not recognized because the indications commonly attributed to hay fever or asthma are not present. Perennial pollen allergy may produce chronic nasal obstruction without sneezing, and without any appreciable mechanical or adenoid factor. Allergy alone may produce recurrent rhinorrhea and nasal obstruction without infection being present, except as a secondary invader. Pollen allergy may produce persistent or recurrent sore throats without pharyngitis or tonsillitis, and intermittent Eustachian tubal blockage without infection. Allergy alone may produce a chronic or intermittent cough without infection of the bronchi, and without wheezing or dyspnoea. Allergy alone may produce recurrent bronchopneumonia with fever, leukocytosis and tachypnea, without wheezing and without pneumococci.

The chronic allergic congestion prevents adequate aeration and drainage of the nasal sinuses. Hence, an upper respiratory infection may develop into a stubborn secondary sinusitis. Mechanical nasal obstruction, due to septal or turbinal irregularities, will be accentuated by the allergic oedema. It is necessary, therefore, in order to relieve this type of chronic nasal victim of his symptoms, to prevent recurrences, and to disprove the laity accusation of "once a sinus, always a sinus," that not only must the allergy be investigated and brought under control, but also any infectious or mechanical naso-sinusal disabilities be remedied. We feel that this is the job of the Otolaryngologist. He is in position to follow the patient closely, his training and experience shows him pathological changes earlier, and he is able to correlate naso-sinusal and allergic treatments which give more rapid and more permanent relief of symptoms.

SOUTHERN CALIFORNIA ENVIRONMENT

The Otolaryngologists' nasal allergy problem in Southern California is difficult because the pollen irritation is perennial. In this semi-tropical climate foods may cause year-around nasal symptoms and "catarrh," but more commonly it is the flora. In this respect we are not fortunate enough to have distinct seasonal variations which give sharply demarcated pollination. Alabama, Arizona, Florida, Georgia, Louisiana, Mississippi, New Mexico, and Texas have the same problem to a similar or less degree as Southern California. Texas is the only state that apparently outdoes Southern California in this respect. For example, among trees, the acacia, pepper, cypress, and eucalyptus bloom all year 'round. Bermuda grass blooms perennially, and many other grasses and plants pollinate in and out of season all year; especially Franserias (Ragweed), Artemesia (Sagebrush), Atriplex (Saltbush), Amaranth and Chenopods.

CHART 3.—*Map of Southern California Districts*



There are two other factors which add to the constant pollinosis. No matter what their season, plants will spring up and flower any time of year if irrigating water or any other source of moisture comes into contact with them. Secondly, although most of the pollens are shed in the Spring, Summer and Fall, the dryness preserves the pollens and they are blown about all year long, often in great numbers and for long distances.

DISTRICTS WITHIN SOUTHERN CALIFORNIA

The allergy problem in Southern California is made more complicated by the fact that within its boundaries there are three varying geographic

areas, with blending but characteristic pollen allergy differences. "Southern California," itself, may be described, polliniferously, as beginning in the north at the Amigdio mountains, which are an east-west spur of the Coastal Range just north of Santa Barbara. The boundary then runs east and south along the Coast Range, and east through the San Gabriel and San Bernardino Mountains, to end in the Sierra Nevada Range which forms the Eastern border of the territory to be considered. The western limit, beginning at Santa Barbara, is the Pacific Ocean. On the South is Mexico.

The three incorporated districts of Southern California will be designated as the Coastal, Intermontane, and Desert Basin areas. These regions have differing floral and meteorological characteristics, and, hence, different pollen allergic problems. The allergic patients will give diverse histories and dissimilar test reactions, although they usually respond equally well to therapeutic injections. The variations of each area blend into the others.

The *Coastal Area* is essentially a ten-mile strip extending immediately along the Pacific Ocean from Santa Barbara and the Amigdio Mountains to San Diego and the Mexican border, with a bulge eastward at the Los Angeles basin region to include metropolitan Los Angeles and the adjacent locality.

The *Intermontane District* emerges from the

TABLE 1.—*Comparative Chart of the Major Features of the Three Southern California Pollen Areas*

Coastal Area	*Intermontane District*	*Desert Basin*
	History	
1) Perennial symptoms.	1) Perennial symptoms with rare seasonal exacerbations.	1) Seasonal symptoms with the perennial case infrequent.
2) Symptoms tend to involve the entire upper respiratory tract, but with the naso-sinusal area most effected.	2) Symptoms tend to affect the naso-sinusal area most frequently, but spread rapidly to the rest of the upper respiratory tract with exacerbations.	2) Symptoms tend to be more localized and do not extend readily.
3) Patients from outside Southern California who continue seasonal allergy develop perennial symptoms in about three years.	3) Patients with seasonal allergy develop perennial symptoms in about three to four years, but have seasonal exacerbations for several years longer.	3) Seasonal type of allergy persists, but usually at different times of the year than previously.
4) Symptoms often precipitated by fog.	4) Symptoms may be precipitated either by fogs or by winds, especially from the desert.	4) Symptoms precipitated by winds.
5) Symptoms not relieved at the sea-shore.	5) Symptoms generally relieved at the sea-shore.	5) Symptoms relieved at the sea-shore.
Coastal Area	*Intermontane District*	*Desert Basin*
	Diagnosis	
1) Examination of the nasal mucosa may be indicative, but not typical of allergic reaction.	1) Examination is usually indicative of an allergic mucosa, but is rarely entirely typical.	1) Examination usually shows typical allergic mucosa.
2) Nasal smear for eosinophilia is usually valueless.	2) Nasal smear for eosinophilia is usually valueless, but occasionally will be positive.	2) Nasal smear for eosinophilia is usually positive.
3) Scratch test reactions produce erythema, with wheal formation small and infrequent. Erythema diagnostic.	3) Scratch test reactions usually give small wheals and moderate erythema. Wheal formation diagnostic and erythema indicative.	3) Scratch test reactions produce large diagnostic wheals.
4) Intradermal tests usually necessary and usually conclusive.	4) Intradermal tests may be necessary and are usually conclusive.	4) Intradermal tests are not necessary and may be dangerous.
5) Eighty per cent of the patients tested will show indicative reactions to scratch and intradermal tests.	5) Ninety per cent of the patients tested will show indicative reactions. Scratch testing will be sufficient in 80 per cent, and intradermal testing will give results in another 10 per cent.	5) Ninety-five per cent of the patients tested will give indicative reactions to scratch testing. Intradermal tests may be used only with the greatest caution.
	Treatment	
1) Best results by correlating otolaryngological and allergic treatments.	1) Best results by correlating otolaryngological and allergic treatments.	1) Best results by correlating otolaryngological and allergic treatments.
2) Injection treatment with the indicated allergic antigen, especially by the perennial method, gives excellent or very good results in 80 per cent of the patients.	2) Injection treatment with the indicated allergic antigen, especially by the perennial method, gives excellent or very good results in 90 per cent of the patients.	2) Injection treatment with the indicated allergic antigen will give good results in 80 per cent of the patients.
3) Nonreactors and poor reactors to the tests comprise about 20 per cent of the patients. Fifty per cent of these cases will respond to empirical allergy therapy — the antigen being made from the pollens in the air at the time of the most severe symptoms.	3) Nonreactors and poor reactors to the tests comprise about 10 per cent of the patients. Twenty-five per cent of these cases will respond well to empirical allergy therapy.	3) Nonreactors and poor reactors to the tests comprise about 10 per cent of the patients. Results are poor to any type of treatment.
		4) Results with the perennial type of patient (less than 10 per cent of the cases), with any type of allergy treatment, are only fair.

Coastal area and includes principally the San Fernando Valley, which lies north and west of Los Angeles, and spreading eastward and southward into the valleys surrounding Pasadena, Monrovia, Pomona, and Santa Ana, then fading into the Desert Basin to the East and South.

The *Desert Basin* comprises the low-lying irrigated Coachella and Imperial Valleys and their extensions.

The major variations between these three Southern California areas in regard to history, diagnosis, and treatment can be shown easiest by means of the following comparative chart. Naturally, there is a gradual transition from one region to the next, so that varying combinations may occur along each of the designated boundaries.

COMMENT

The continual exposure of susceptible individuals to pollen antigens develops a low-grade resistance which is not sufficient to prevent the allergic lesions, but which results in minimum reactions to testing. The large wheal formation, which is considered essential for a positive reaction in other parts of the United States, is found most often in the Desert Basin area of Southern California. Small wheal formation is usually produced in the Intermontane district and erythema in the Coastal region. However, the erythema and small wheal formations of these two areas are as diagnostic as the large wheals seen in other localities in the United States.

The unremitting pollinosis gradually transforms seasonal types of allergy into perennial forms within three to four years in the Coastal and Intermontane regions, if adequate treatment is not instituted.

Between 80 and 95 per cent of the patients, who have been diagnosed clinically as having a primary allergy, will show sufficiently indicative reactions, so that the offending pollens can be incorporated into a specific treatment antigen. The other individuals who have produced equivocal or no reactions to the testing usually will provide a hint in the carefully-taken history, so that certain pollen combinations may be selected and given empirically with gratifying results.

In the Desert Basin it is necessary to use high concentrations of the two or three more active pollens in order to obtain results. In the Coastal and Intermontane areas a considerable number of the offending pollens, in moderate concentration, may be incorporated into one treatment antigen. The danger of anaphylaxis is ever present in the Desert Basin, but, due to the acquired low-grade resistance of the Coastal or Intermontane patient, it is less serious a factor in these areas. Oriental patients, however, must always be treated with the greatest of care.

CONCLUSIONS

1. Recurring "sinusitis," "bronchitis," "constant colds," and "catarrh" are terms often used because of ignorance of the true etiology.

2. These upper respiratory tract lesions, especially in Southern California, usually are due to an unrecognized or hidden pollen allergy. This allergy may cause a secondary sinusitis or other infection of the upper respiratory tract due to blockage, in the presence of a coincidental bacterial invasion.

3. Any upper respiratory infection which tends to recur, or is stubborn in improving, probably has an allergic background; ruling out, of course, structural abnormalities and secondary infections.

4. The basic pollen allergy problem in Southern California, and similar climatic areas such as Alabama, Arizona, Florida, Georgia, Louisiana, Mississippi, New Mexico, and Texas, is unusual and very difficult, due to the perennial pollens in the air.

5. Southern California contains three pollniferously differing districts which produce varying histories, clinical findings, and reactions to allergic testing.

6. The continuous exposure to pollens builds up a low-grade resistance, which tends to produce minimum results to allergic tests without being of benefit to the patient. This unremitting pollen absorption causes seasonal types of allergy to become perennial in about three to four years, if adequate treatment is not instituted, in the Coastal and Intermontane regions.

7. The Otolaryngologist is in the most advantageous position to correlate the necessary nasosinusal and allergic treatments in order to obtain the most rapid and permanent relief of the symptoms.

8. Perennial pollen treatment, including empirical treatment with the indicated pollens in cases where the tests have been inconclusive, have been of great benefit in these so-called "uncurable" cases of recurrent "sinusitis," "constant colds," "catarrh," and "bronchitis."

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CHEMICAL INJURIES OF THE EYE: THEIR TREATMENT

WITH SPECIAL REFERENCE TO WAR GASES

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CHEMICAL injuries to the eyes occur as a result of splash, spray, or gaseous contact with exposed parts such as skin, conjunctiva, or cornea tissue primarily. The irritation set up and secondary infection may lead to involvement of deeper structures such as the sclera, the anterior or posterior uveal tract, continuing on to panophthalmitis and phthisis bulbi.

SYMPTOMS AND SIGNS

Subjective Symptoms. — Lacrimation, photophobia, stinging pain, and blurring of vision are

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followed by aggravation of the symptoms with anxiety and apprehension which must be allayed by adequate sedation and reasonable assurance, as well as the indicated local treatment, all depending on the chemical agent and the extent of the injury.

Objective Findings.—The skin and conjunctiva show first, second, or third degree involvement with hyperemia, tearing, steaminess of cornea or possibly eschar. Marked swelling of lids and conjunctiva ensues and ulcerative keratitis may follow.

Sequellae.—If the skin suffers third degree burn the resulting eschar produces an eversion of the lid or cicatricial ectropion. If the conjunctiva suffers similarly symblepharon or entropion results from the contraction of the scar; the eyelashes are turned against the eyeball producing intolerable irritation and at times secondary ulcerative keratitis.

Should the cornea be directly attacked opacification results in proportion to the depth of penetration of the chemical agent. Nebulae, maculae, and dense leucoma are the sequellae, the latter sometimes breaking down with frequent recurrences. Calcium deposition is common.

ALKALIS

Of the alkali burns the most frequently encountered agent is lime which often causes deep penetrating trauma on account of its tendency to continue its activity. Contact should be promptly followed by profuse and thorough lavage of all particles from the cornea and conjunctival sac with boric acid, saline or water whichever is most readily available. Particles which tend to stick may be dislodged with applicator or forceps. The cornea should be anesthetized with one-half per cent pontocain and an eye bath of ten per cent neutral ammonium tartrate used, this process to be repeated every two to three hours for several days. Neutral ammonium tartrate dissolves the calcium carbonate which forms in the tissues from lime. After this fresh castor oil may be instilled and dark glasses worn. Do not cover the eye with any dressing from which the escape of tears may be impeded; cold boric compresses, frequently changed may be used however. One-half per cent pontocain is used to quiet sensory pain and one per cent atropin to abate pain of ciliary spasm.

Severe blepharospasm may be controlled by injections of the terminal branches of the seventh nerve with novocain to facilitate treatment.

ACIDS

In contradistinction from alkalis, acids act quickly, fix quickly and do not continue penetration. The eye should be promptly flushed with one to two per cent sodium bicarbonate, saline, or plain water. Then pontocain, atropin, castor oil, compresses, and dark glasses may be utilized, but again—do not bandage.

SOLVENTS

Ether and ethyl chloride do no harm whereas alcohol of over fifty per cent concentration will destroy the epithelium of the cornea. Regeneration takes place, however, in one to two days usually without impairment of vision.

Acetone also destroys the epithelium and may set up a keratitis resulting in corneal opacity. Carbon tetrachloride used in cleaning fabrics and carbon bisulfide used in the rubber industry act similarly to acetone.

WAR GASES

Tear Gas.—Tear gas (chloracetophenone) is as the name implies a lacrimator and is intended to disable by producing discomfort and belpharospasm, but if the contact is liquid rather than gaseous it may set up an irritative keratitis, subsequent fibrosis, corneal opacity and its consequent loss of vision.

Treatment comprises voluminous flushing with boric, saline, or water, as available. Four-tenths per cent (0.4 per cent) sodium sulfite in seventy-five per cent glycerin and twenty-five per cent water is a specific however, and should be instilled every hour for one to two days, using one-half per cent pontocain as a preliminary anesthetic. Use castor oil, dark glasses, compresses, but no bandage.

The skin is treated by wiping with cotton balls soaked in a solution of four per cent sodium sulfite in fifty per cent alcohol.

Mustard Gas.—This gas chemically known as dichlorethylene sulfide is soluble in the oil of the skin, and combines with water to produce hydrochloric acid in the tissues. It produces an immediate irritation which has a mild appearance at first, but soon its penetrating effect produces desquamation of the corneal epithelium, conjunctival edema, and sometimes corneal destruction, iritis, and even panophthalmitis.

The best lavage is sodium bicarbonate one to two per cent which neutralizes the hydrochloric acid. Since dichlorethylene sulfide is soluble in oil, castor oil should not be used. Bandages should not be used. Late swelling and pain is usually severe so adequate sedation will be required. Recurrent ulcerative keratitis may persist for years.

Lewisite.—All that has been said about mustard gas applies to this gas.

Phosgene.—The writer knows of no adequate neutralizing agent for phosgene and its treatment comprises lavage, local and systemic sedatives, no castor oil, no bandages. Its destructive action is similar to mustard gas and Lewisite.

727 West Seventh Street.

The Art of Medicine is largely the art of noticing.—*J. A. Ryle.*

We American writers have one of the great stories of the world to tell, if we have the wit to tell it truly. There is no surer way that I know, of fitting ourselves for the future, than by gaining an understanding of what the ordinary citizen, who has to work for his living, has been doing and thinking and hoping through the course of formal history.—Walter D. Edmonds.

CALIFORNIA MEDICAL ASSOCIATION

This department contains official notices, reports of county society proceedings and other information having to do with the State Association and its component county societies. The copy for the department is submitted by the State Association Secretary, to whom communications for this department should be sent. Rosters of State Association officers and committees and of component county societies and affiliated organizations, are printed in the front advertising section on pages 2, 4 and 6.

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OFFICIAL NOTICE

72ND ANNUAL SESSION CALIFORNIA MEDICAL ASSOCIATION, LOS ANGELES, MAY 2-3, 1943

Re: Reports of Meetings

The May issue of CALIFORNIA AND WESTERN MEDICINE is in press at the time when the California Medical Association convenes to hold the 72nd annual session.

Full reports of the proceedings will appear in the June number of CALIFORNIA AND WESTERN MEDICINE. It is possible, however, to make the statement that the general opinion of the session was most favorable, general and section meetings being well attended and of value. The military exhibits and films were likewise of interest.

The attendance was good as evidenced by the following registration figures:

Total C.M.A. Registration at Los Angeles was 1184.

Total Woman's Auxiliary registration was 174.

The "Dinner to the President" was attended by 933 physicians and families, every seat in the Biltmore Bowl being taken in advance, with more than one hundred seeking places that were not available.

CALIFORNIA COMMITTEE ON PARTICIPATION OF THE MEDICAL PROFESSION IN THE WAR EFFORT†

WAR MANPOWER COMMISSION

Editor's Note.—The four statements which follow are referred to in a letter dated May 6, 1943 and signed by Frank H. Lahey, M. D., Chairman of the Directing Board of the Procurement and Assignment Service for Physicians, Dentists and Veterinarians. For copy of Dr. Lahey's letter and editorial comment, see in this issue on page 263.

The enclosures referred to in Dr. Lahey's letter appear here in the following sequence:

I. Statement of the Surgeon General of the United States Army.

† Harold A. Fletcher, M. D., 490 Post Street, San Francisco, is the State chairman on Procurement and Assignment Service, with supervision of all counties north of the fourteen southern counties.

Associate California chairman for the fourteen southern counties is Edward M. Pallette, M. D., 1930 Wilshire Boulevard, Los Angeles.

Doctors desiring to go into the Army may have their papers prepared and receive orders for physical examination from the Officer Procurement Service, 328 Flood Building, San Francisco, in charge.

From any of the fourteen southern counties, they may apply to the Officer Procurement Service, 1418 U. S. Post Office and Courthouse Building, Los Angeles, Major M. L. Murrell, in charge. Telephone: MAdison 7411, Extension 684.

The Office of Naval Officer Procurement for the northern section of California is in charge of Capt. C. L. Arnold, U.S.N. The Senior Medical Officer is Capt. Philip K. Gilman, U.S.N.R. The office is located at Room 515, 703 Market Street, San Francisco. Telephone: EXbrook 3386, Local 46.

The Naval Office of Procurement for the southern section of California is in charge of Admiral A. Johnson, U.S.N. The Senior Medical Officer is Captain John C. Ruddock, U.S.N.R. The office is located at 411 West Fifth Street, N.W. Corner of Hill, Los Angeles. Telephone: MIchigan 8641.

II. Statement of the Surgeon General of the United States Navy.

III. Statement of the Surgeon General of the United States Public Health Service.

IV. Statement of the Chairman of the Directing Board of Procurement and Assignment Service for Physicians, Dentists and Veterinarians.

I

Statement of the Surgeon General of the United States Army

The Army is increasing in size; more medical officers are required. New units are being formed and many new general hospitals are under construction at many points in the United States. Some basic training must be given to medical officers before they are assigned to purely medico-military duties; for this reason, they are needed one or two months prior to actual assignment. For the protection of the health of the civilian population, the quotas for physicians must be fairly distributed throughout the country. Certain states are far behind; they will, it is hoped, do everything possible to furnish their quotas at once.

II

Statement of the Surgeon General of the United States Navy

In order to plan intelligently I have reviewed the personnel situation in the Medical Department of the Navy. There is a deficit of approximately nine hundred medical officers for the next six months, based on minimal requirements. The Bureau of Medicine and Surgery calls medical officers to active duty when billets are available, does not build up too large a Reserve at any time. Consequently, procurement must go on in an orderly fashion, if we are to meet the demands that will be placed upon us as the offensive fighting develops. We cannot afford to have the deficit increase beyond its present level; if it does we will not be able to give first-class medical service to our wounded.

The Medical Department of the Navy is charged with maintaining the health of all the personnel of the Navy and the Marine Corps; in addition it must care for the dependents of the officers and men. We look to the medical profession of our nation to come forward with the available doctors that can be spared from civil life to aid in our military necessity. In the main, the profession has responded nobly. There are some localities where this is not so. In those localities the medical profession should cause the pressure of public opinion to bear on all eligible doctors and thereby bring to their attention the seriousness of failing to do their patriotic duty.

The medical profession is faced with a challenge of furnishing medical service to the Armed Forces and to the civil population during the active state of war and in the post war period, which we hope is not too far distant. Should the profession fail in either regard many forces may develop that will destroy the practice of medicine as we know it. This would be disastrous and it is something that we cannot afford to allow to come about. In all seriousness, the doctors of medicine in the United States should take stock carefully of their own immediate situations and should give every assistance in planning to see that medicine plays its responsible part in this and coming years.

III

Statement of the Surgeon General of the United States Public Health Service

During the next twelve months, the Public Health Service will require approximately 600 medical officers for full-time active duty in the reserve commissioned corps. These physicians will be recruited on an average of 50 a month—25 for service in the U. S. Coast Guard, and 25 for general service.

In addition to the medical officers assigned to the Coast Guard, physicians are needed for duty in the Marine Hospitals and the medical program of the War Shipping Administration, as well as for detail to general public health work in State and local health departments, and for such specialized war programs of the Public Health Service as tuberculosis control, venereal disease control, industrial hygiene, and community medical services.

The Service also expects this year to commission some 5,000 physicians in the inactive reserve. These doctors will be available for active duty in the event of acute emergency in their own or nearby communities. They will not be called for active duty unless an acute emergency exists, and will be retained only for the duration of such an emergency. This recruitment of inactive officers is undertaken as a part of the coöperative program of the Public Health Service and the Office of Civilian Defense.

The needs of State and local health departments for physicians have increased greatly during the past year. In January, 1942, it was estimated that State and local health departments would need 600 physicians. As of January, 1943, the exact needs have not been determined, but the Public Health Service has, at the present time, requests from the States for 185 medical officers to be assigned to duty in war areas alone.

According to reports from State Procurement and Assignment chairmen, as of March 23, 1943, 286 additional doctors for civilian practice are needed in 176 counties located in 38 States. Another 22 counties in the same States report a shortage of physicians but do not specify the numbers needed. In the remaining 10 States, no needs were reported.

These 198 counties reporting immediate needs represent only 7 per cent of the 2,654 counties in the 38 States, and only 6 per cent of all counties in the country. Nevertheless, it is apparent that civilian communities are feeling the pinch of the physician-shortage increasingly, since experience has shown that local needs become acute before they are expressed in formal reports. In the joint studies made in 42 areas by the Public Health Service and the Procurement and Assignment Service, it has been determined that 59 physicians and 5 dentists, or 64 medical and dental personnel, are needed in these areas —an average of 1.5 per study. The Public Health Service has been requested to supply 13 of these physicians and dentists, or 23 per cent of the determined need.

On the basis of these 42 studies, it is estimated that 500 physicians and dentists will be needed in 332 areas to be surveyed in the next coming fourteen months, or by June 1, 1944. It is anticipated that 80 per cent of these, or 400, will be supplied by voluntary relocation through the regular channels of Procurement and Assignment, and that the Public Health Service will be requested to assist in meeting the needs for the remaining 20 per cent, or 100 physicians and dentists. This may be done either through financial assistance to physicians desiring to relocate in areas requiring their services, or through assignment of Public Health Service personnel upon request of the proper authorities.

Although it is impossible to project with accuracy the 1943 needs of civilian communities, we must face the fact that the shortage undoubtedly will increase during and after the filling of the 1943 military quotas; and that the chances of meeting civilian needs as well as replacing physicians who die or withdraw from practice be-

cause of disability, will correspondingly decrease. Furthermore, we cannot predict at this time the possible needs of certain rural areas, which now may be adequately supplied but which will require additional public health and medical services during 1943, should the Government move a large number of farm families into these areas for the food production drive. It is believed that joint action of the Public Health Service and the Procurement and Assignment Service will serve to meet urgent needs in civilian communities.

IV

Statement of the Chairman of the Directing Board Procurement and Assignment Service for Physicians, Dentists and Veterinarians

Figures are now complete on the 1942 quotas for supplying physicians of the various States. Forty States have exceeded the 100 per cent figure of their quotas. Five States were above 90 per cent of their quotas. Four States—New York, Connecticut, Massachusetts, and Nevada were below 90 per cent of their quotas.

Nevada is the lowest State, but has a total quota of but 35 doctors. It has provided 23 and deserves special consideration because its population is thinly scattered over wide areas.

This statement would not imply any reflection on the patriotism of those members of the medical profession who have been marked available by the Procurement and Assignment Service in these three States and who have not sought a commission. I would only present the facts and let each one draw from these facts whatever deductions he individually chooses.

Certain unavoidable considerations must be faced in these figures. Four States failed to provide 90 per cent of their 1942 quotas of doctors for the services. Three of these States—New York, Connecticut, and Massachusetts, are Eastern Seaboard States and among the most populous ones in the Union. These populous States have large cities in them which now have more doctors per thousand persons than most other parts of the country. Largely because those doctors marked available by the Procurement and Assignment Service have not sought commissions, these States are below their quotas.

Unless more of the doctors found available for military service by the Procurement and Assignment Service in these cities apply for a commission in the armed forces with reasonable promptness still more doctors must come from rural communities. This will greatly complicate the problem for those communities in their own and other States since many rural communities are already none too well supplied with doctors. Such inequalities in medical service as now exist are practically insurmountable for the Procurement and Assignment Service with its present limited authority. With all these facts in mind, with the responsibility of medicine to the country and to itself such as it is, *the quota figures* particularly in New York, Connecticut, and Massachusetts *should be brought up to par by an intensive effort of the State Medical societies through their executive bodies preferably by an organized State Medical society campaign.*

The provision of doctors for the armed forces is not only the special obligation of medicine but a responsibility which it acknowledges and accepts as its part in the war effort. Each State that has not met its 1942 quota will be kept informed of its position in relation to its quota and its position in relation to other States. Otherwise, a State is denied the pardonable pride of satisfaction in meeting its quota or pampered against facing a distasteful position in relation to other States.

PRO PATRIA

Note. The Editor will be pleased to receive letters from C.M.A. members, who in turn have heard from colleagues in military service. (The original letters will be returned after "copy" has been set in print.)

Members of the Association, who are in service with the Armed Forces in the United States or elsewhere, are also invited to write the Editor concerning their experiences. Colleagues in civilian practice will be happy to hear from them.—Ed.

(COPY)

From Albert G. Bower, MC
U. S. Naval Hospital
Navy No. 10, C/o F.P.O.
San Francisco, Calif.

May 5, 1943.

Dear Doctor Kress:

Many thanks for your kind letter and the enclosed copy of Captain Buddy Horner's Pro Patria letter. It sounded like a roster of San Francisco's finest. However, there are a few more fine Californians working around here from other parts and counties. There is Fetter and McPherson from San Diego; Gates from Santa Barbara; Barnum, Butt, and Wright from Pasadena; Silver and Joe Stevens from Hollywood; Rosove from Santa Monica; Larson, Smedley, Harold Cummings, Roy Falconer, Von Briesen, Carter, Kaplan, from Los Angeles; Gunther from Long Beach; and not mentioned in a previous letter, Leo Stanley and Rapaport from up North. In fact, we have quite a California outfit.

The duty, here, is a tour at Shangrila. Anyone that gripes at this duty just doesn't know what a tough tour of overseas' duty can be like when the going is really hard. Of course, the gang miss their wives and families, and their home associations and work, but in so far as a tour of duty away from the mainland can be made pleasurable, this is it. After all, we're here to help win a war! This new hospital is the finest owned by any of the armed services off the mainland. Only recently completed, everything is modern and up-to-date. We are moderately busy, and with the changing tides of war, may be much more so in the future. Our colleagues, we greet you.

Aloha,

ALBERT G. BOWER,
Cdr. Albert G. Bower, MC-V (S) USNR.

(COPY)

From Otto H. Pflueger, M.C.
Air Corps, United States Army

April 5, 1943.

Dear George:

Greetings from Blythe, California. I got back to California but not to a particularly lovely part of the same. As you must know, Blythe is down here in the middle of the desert on the California-Arizona border—a hundred miles or more from nowhere. Wind, sand and heat—plenty of the last two especially and often of the first. The desert has a certain charm, however, which I like—the nights are beautiful. Of course they are only used for sleep and/or movies and reading and writing.

Miami Beach was lovely and I enjoyed it although there was plenty work. Got in good shape (physically).

I have been here just over two weeks—we have a good hospital of the type you undoubtedly know the army has

in these locations—about 150 beds. I am chief of the surgical service—have about 50 beds—another surgeon is here—we have good equipment—not a great variety but enough. We don't expect to do colon and gastric resections and we hope no accident work of any great moment, because that means planes down which we do not want.

Would you be so good to send me the last two or more issues of C. & W. M., and then monthly as long as I am here? Would like to know about the Los Angeles meeting. With my best regards, I am,

Sincerely,

OTTO.

CAPT. OTTO H. PFLUEGER, M.C.,
Station Hospital, Army Air Base, Blythe, Calif.

Medical Journals—For Colleagues in Military Service:

In former issues editorial comment was made on a plan to forward medical journals to the Hospital Stations of Army, Navy and Air Force camps now located in California.

This work is being carried on by the California Medical Association—through its Committee on Postgraduate Activities—in coöperation with the medical libraries of the University of California, Stanford, and the Los Angeles County Medical Association.

The addresses of the three libraries follow:

U. C. Medical Library, The Medical Center, 3rd and Parnassus, San Francisco, California.

Lane Medical Library, Clay and Webster Streets, San Francisco, California.

Los Angeles County Medical Library Association, 634 South Westlake, Los Angeles, California.

If more convenient, you can send journals, via "Railway Express Agency," collect, to: C.M.A. Postgraduate Committee, Room 2008, Four Fifty Sutter, San Francisco, California. Railway Express Agency addresses: In San Francisco, at 635 Folsom (EX 3100); in Los Angeles, at 357 Aliso (MU 0261). The "Railway Express Agency" will call for packages and will collect costs from C.M.A. The P. G. Committee will forward to camps.

Women Physicians now Eligible for Commissions in the United States Army and Navy

H. R. 1857, sponsored by Congressman Sparkman, became a law on April 17, 1943, when President Franklin D. Roosevelt attached his signature thereto.

Text of the new law follows:

(H. R. 1857, 78th Cong., 1st Sess.)

A Bill to provide for the appointment of female physicians and surgeons in the Medical Corps of the Army and Navy.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That hereafter during the present war and six months thereafter there shall be included in the Medical Departments of the Army and Navy such licensed female physicians and surgeons as the Secretary of War and the Secretary of the Navy may consider necessary, whose qualifications, duties, and assignments shall be in accordance with regulations to be prescribed by the Secretary and who shall be appointed and at his discretion removed by the Surgeon General of the Army and Navy, subject to the approval of the Secretary of War or the Secretary of the Navy. Those appointed shall be commissioned in the Army of the United States or the Naval Reserve, and shall receive the same pay and allowances and be entitled to the same rights, privileges, and benefits as members of the Officers' Reserve Corps of the Army and the Naval Reserve of the Navy with the same grade and length of service: *Provided,* That female physicians and surgeons appointed under this Act shall only be assigned to duty in hospitals or other stations where female nurses are employed.

Young Physicians Hit in A.M.A. Journal

Refusal to Enlist in Armed Services Rapped

Chicago, March 25.—(INS.)—Young available physicians who have failed or refused to volunteer as medical officers in the armed forces were severely arraigned today in an editorial in the *Journal* of the American Medical Association.

Advocating publication of their names in state medical journals, the editorial demanded:

"Let them be called before the bar of public opinion."

The *Journal* said that at a recent meeting in Washington of the directing board of the procurement and assignment service for physicians and veterinarians with the officer procurement service of the United States Army it was clearly set forth that the recruitment of medical officers was lagging.

"The responsibility," the editorial said, "rests unquestionably on the failure of the young available physicians in the large cities of the country, particularly those of the eastern seaboard, to volunteer.

"New York, Brooklyn, Boston and some of the larger communities in Connecticut, New Jersey, Pennsylvania and California have failed even to approximate their quotas."—Stockton *Record,* March 25.

U. S. Doctors: Nation Faces Medical Problem as the Military Absorbs Supply

Washington.—(AP.)—About one-third of the nation's doctors in full-time practice are now in the armed services, the Office of War Information recently said in a warning that the medical situation "as a whole is not now out of control, but unless remedial steps are taken soon it will grow progressively worse."

The OWI said that in too many cases physicians were recruited for the armed services without sufficient regard for the welfare of the civilian population. It added:

"There are, however, enough doctors remaining in private practice to give adequate care to the civilian population, provided they can be properly distributed and according to special abilities."

The OWI said doctors now in the armed services total between 40,000 and 45,000 and as the additional physicians are called to military service, "doctors in critical areas—many of them elderly—may succumb to exhaustion from overwork."

The OWI also made these observations:

"In some communities local medical groups have resisted attempts to relocate outside doctors in their locality. In a number of instances (there was) disinclination of medical groups to allow a physician paid by the public health service to practice medicine in a particular community.

"A number of doctors questioned were against allowing refugee physicians to practice.

"The system in use at present to apportion doctors between the armed forces and the civilian population is inadequate.

"In certain cases pressure was applied to doctors who were reluctant to enter the service. A quota was set in each state for the recruiting of doctors and the states were not supposed to go beyond those quotas. In many cases they did."

Explaining the scope of its report, the OWI said:

"OWI representatives traveled through the South, the Midwest, the West, the Eastern seaboard—in three distinct types of communities: farming regions, where health problems existing for years have been intensified by war; small, quiet towns that have mushroomed overnight into close-packed centers around war industry and military

encampments; large cities where ordinary congestion has been aggravated by war activity.

Luxury Medicine

"Although there are areas critically in need of doctors because of withdrawals for the armed forces—a need frequently increased by expansion of the population for war industry—so far the health of the nation as a whole has not been seriously impaired by the doctor shortage. Doctors these days are not only working overtime; they are—most of them—working practically all the time and in total disregard of their own health.

"The number of communities critically in need of doctors is not great compared with the total number of communities in the United States. Those in need are, however, among those most vital to our war program.

"The voluntary relocation of physicians from communities where there is an abundance of doctors to areas in acute need of doctors has proved extremely difficult, and has not resulted in a solution to the problem.

"Luxury medicine, to which some Americans have become accustomed, is out for the duration. We can no longer afford to call doctors for imaginary ailments, and we must make the best and most efficient use of the medical facilities we have. . . . —San Francisco *Chronicle*.

Pennant to Identify Vehicles in Blackout

(COPY)

OFFICE OF CIVILIAN DEFENSE
Washington, D. C.

A uniform system of identification of emergency vehicles to enable them to operate during real or practice air-raid alarms was announced by the Office of Civilian Defense in Operations Letter No. 111, which is a supplement to Operations Letter No. 97.

The primary identifying device is a white pennant measuring 18 inches along each side with a 6-inch basic Civilian Defense insigne; that is, the letters CD in red inside a white triangle superimposed on a red circle. The pennant is to be attached to the left front portion of the vehicle.

To identify emergency motor vehicles at night, the Operations Letter further prescribes a headlight mask to be used over the right headlamp. This mask may be made of any opaque material that can be easily, quickly, and securely fastened to the headlamp. It is intended for use where blackout regulations permit the use of headlights; in coastal dimout areas it should be used in conjunction with dimout equipment. The design of the mask embodies the "CD" insigne 2½ to 3 inches in diameter in green.

Vehicles entitled to use the emergency identification include (a) vehicles of the armed forces of the United States or of her allies or other vehicles acting under orders or traveling with permission thereof; (b) vehicles of fire departments and governmental police agencies; (c) ambulances and rescue cars and other vehicles converted to such use in emergency services; (d) public utility repair vehicles operating in emergency service; (e) vehicles in emergency service as defined by State Civilian Defense authorities.

Use of the pennants and masks described was made mandatory for the 16 states and the District of Columbia in the Eastern Defense Command in an administrative order issued by the Director of Civilian Defense in accordance with the new Air Raid Protection Regulations which went into effect February 17. The Operations Letter recommends that all States adopt the definition of emergency motor vehicles and the methods of identification prescribed. Although many states have already adopted different methods of identifying emergency motor vehicles, it was urged that all states adopt the new devices. It was pointed out that a uniform system is particularly important in order that emergency motor vehicles which may be crossing state lines may not face unnecessary interference.

* * *

Transportation Plans for Civilian Defense

Transportation for casualties from scenes of disaster to hospitals and for injured persons or other patients removed from Casualty Receiving Hospitals to Emergency Base Hospitals are included in plans for emergency transport service during war disasters, described in recent Operations Letters issued by the Office of Civilian Defense.

Plans for local transportation are centered in the Transport Officer of the U. S. Citizens Defense Corps. It is the duty of the Transport Officer to maintain inventories of local equipment that can be used by the various emergency services of the Citizens Defense Corps, and he is responsible for organization, training, and supervision of volunteer drivers' units. Such equipment may include passenger cars, station wagons, motorcycles, ambulances, and other private vehicles. The instructions provide, however, that ambulances and cars or trucks used as improvised ambulances, with their drivers, should be assigned regularly to the Emergency Medical Service and be under its direction.

Through joint action of the Office of Defense Transportation and the Office of Civilian Defense, concurred in by the War and Navy Departments, local commercial motor vehicles, including taxicabs and trucks of small operators, which are now under the jurisdiction of the Office of Defense Transportation, have been released to and also are available to the Transport Officer for local service in case of war emergency. He may make use of such vehicles immediately, without application to the ODT.

For transport facilities needed outside the local area, such as might be required for evacuation of civilians or for transfer of injured persons to Emergency Base Hospitals in other cities or rural areas, the OCD and the ODT are coöperating in the organization of motor transport units in the larger common, contract, and private motor carriers of the critical areas of the country. These units, which will be trained in convoy service, will be provided by the ODT on request of the local Commander of the Citizens Defense Corps through the State Transport Officer and proper ODT district managers. ODT is at present developing an organization in the critical areas of the country under which its district managers will make contact with the local Transport Officers to make certain that each community is organized to function under the plan.

Operations Letter No. 114, issued March 3, which describes the above arrangements, urges coöperative planning between the Citizens Defense Corps and such agencies as the American Red Cross, the Women's Defense and Ambulance Corps, and local or state automobile associations or clubs, in order that several agencies may not seek to mobilize the same equipment and drivers independently, but may do so in coöperation. It is pointed out, for instance, that most local Red Cross chapters have permanent transportation committees to provide motor transport facilities for disaster relief. By coöperative planning, such facilities can be made available also to the Citizens Defense Corps.

Military Clippings.—Some news items of a military nature from the daily press follow:

Mental Unfits 5 in 13, Army Figures Show

Chicago, March 31.—(UP.)—Five of every 13 men reporting for induction in the armed services are rejected as mentally unfit, the American Medical Association said today.

It has been reported that 75 out of each 1,000 called by their draft boards were turned down last year because they were suffering from either mental or nervous disorders. Despite vastly improved methods in detecting such cases, approximately four out of each 100 manage to pass the screening tests and are admitted to the Army or Navy, only to be discharged later.

The rates were considerably higher in 1918, when seven of each 1,000 were discharged. Only 20 per thousand were rejected before their admittance, however, because doctors were unable to diagnose the disorders as satisfactorily as they have during recent years.

No blame is placed on any branch of the service for its acceptance of the mentally unsuited, but it is suggested that an increased study of the nervous diseases be made by physicians to provide a more accurate detection of such cases.—Long Beach *Sun*, April 1.

U. S. Doctors: Nation Faces Medical Problem as the Military Absorbs Supply

Washington, March 29.—(AP.)—About one-third of the Nation's doctors in full-time practice are now in the armed services, the Office of War Information said today in a warning that the medical situation "as a whole is not now out of control but unless remedial steps are taken soon it will grow progressively worse."

The OWI said that in too many cases physicians were recruited for the armed services without sufficient regard for the welfare of the civilian population. It added:

"There are, however, enough doctors remaining in private practice to give adequate care to the civilian population, provided they can be properly distributed and according to special abilities."

The OWI said doctors now in the armed services total between 40,000 and 45,000 and as the additional physicians are called to military services "doctors in critical areas—many of them elderly—may succumb to exhaustion from overwork."

Refugee Doctors

The OWI also made these observations:

"In some communities local medical groups have resisted attempts to relocate outside doctors in their locality. In a number of instances (there was) disinclination of medical groups to allow a physician paid by the public health service to practice medicine in a particular community.

"A number of doctors questioned were against allowing refugee physicians to practice in their communities despite the obvious need for additional medical care.

"The system in use at present to apportion doctors between the armed forces and the civilian population is inadequate.

"In certain cases pressure was applied to doctors who were reluctant to enter the service. A quota was set in each state for the recruiting of doctors and the states were not supposed to go beyond those quotas. In many cases they did."

Explaining the scope of its report, the OWI said:

"OWI representatives traveled through the South, the Midwest, the West, the Eastern seaboard—in three distinct types of communities: Farming regions, where health problems existing for years have been intensified by war; small, quiet towns that have mushroomed overnight into close-packed centers around war industry and military encampments; large cities where ordinary congestion has been aggravated by war activity.

Luxury Medicine

Although there are areas critically in need of doctors because of withdrawals for the armed forces—a need frequently increased by expansion of the population for war industry—so far the health of the Nation as a whole has not been seriously impaired by the doctor shortage. Doctors these days are not only working overtime; they are —most of them—working practically all the time and in total disregard of their own health.

Emphasizing the difficulties of relocating doctors to areas in need, the OWI said doctors who already had gone to war sometimes "and quite understandingly, show a definite antipathy to permitting outside doctors to come into their home communities and take over their practice."—San Francisco *Examiner*, March 30, 1943.

OWI Warns on Shortage of Doctors

Relocation of Civilian Physicians Urged as Health Measure

Washington, March 29.—(INS.)—The Office of War Information (OWI) today warned that with one-third of the Nation's doctors already in uniform, civilian health and working power will be jeopardized unless the present drain on the medical profession is halted immediately.

Following a survey of twenty states, OWI declared that *"the situation as a whole is not now out of control,"* although it reported these findings:

1. Most doctors are working practically all the time and in total disregard of their own health.
2. The number of communities critically in need of doctors is not great but those in need are among the most vital areas to our war program.
3. In too many cases, physicians were recruited for the armed services without sufficient regard for the welfare of the civilian population.

Legislation Implied

Although 40,000 to 45,000 doctors of the 135,932 registered in September, 1942, have gone into the Army, OWI declared that the remaining doctors would be enough to meet the Nation's needs if they were carefully distributed.

However, voluntary relocation of physicians would not solve this problem, the information agency declared, implying that only legislation permitting compulsory redistribution of the remaining doctors will remedy the situation.

OWI pointed out that in many communities the calls can be handled by fewer doctors than formerly were available.

Aid Suggested

The shortage also can be offset, it explained, by well instructed residents, by physically disabled interns who are unable to serve with the armed forces, by retired doctors, by those of the 8,000 women doctors who have not gone into service and by 6,000 refugee doctors.

There are now approximately eight doctors to 1,000 soldiers, whereas the War Manpower Commission's goal for civilians is one doctor to 1,500, said the OWI.

Epidemics Threaten

The survey listed some areas as having only one doctor to 5,000 or 6,000. Some of these sections, moreover, are crowded war industry areas, threatened by epidemics due to lack of sewage systems, inadequate sanitary facilities and questionable supplies of drinking water.

The medical profession has already taken some steps to ease the shortage in doctors, however, by establishing group clinics, pooling facilities and alternating their calls, the OWI reported. Some communities have brought in trained nurses to substitute for unobtainable doctors.

Coöperation Urged

OWI called on employers to coöperate by organizing medical care for their workers. It also urged physicians to coöperate fully with the state service programs which embrace a wide variety of medical treatment for chronic illness, hospital treatment and prenatal care.

"Luxury medicine, to which some Americans have become accustomed, is out for the duration," the OWI concluded.—San Francisco *Chronicle*, March 30, 1943.

Absence of Air Raid Shelters in Pasadena Surprises OCD Official

Question of Liability Not Raised in Other Cities, Says Dr. George Baehr, National Medical Director

Surprise that no public buildings in Pasadena had been designated as air raid shelters was expressed yesterday by Dr. George Baehr, director of Emergency Medical Services for the United States Office of Civilian Defense.

When informed at a press conference at OCD sector headquarters here that the question of liability had entered into the decision of Board of City Directors not to designate any shelters, Dr. Baehr said:

'Shouldn't Enter Into It'

"This question has not entered into the designation of shelters either abroad or in other parts of the country and should not enter into it here. In the cities on the East Coast there are designated shelters in each block in the business district. The question of liability has never arisen.". . .

Dr. Baehr stated that frequent rehearsals of air raids are held on the East Coast and that during these rehearsals all vehicular and pedestrian traffic ceases and the streets are cleared of persons.

He highly praised the new War Powers Bill which is now before the State Legislature as one of the finest

measures of its kind he had ever seen. This bill makes it illegal for any person unless engaged in the pursuit of civilian defense work to remain on the street or sidewalks after the air raid warning siren has sounded.

Organizes Defense Groups

The medical officer has just returned from Hawaii, where he assisted in organizing the various civilian defense groups which are taking over defense of the civilian population now that martial law is being removed.

"Protection of cities against destruction during a bombing attack is the problem of the civilian," Dr. Baehr said. "The Army will have its hands full and you cannot expect the Army to extinguish the fires, care for the injured and perform the hundred other duties of protecting the civilian population. It is up to each citizen to enlist in some type of civilian protection service and train himself to perform some useful function when the bomb-destruction during a bombing attack occurs."

The medical officer said that after his visit to Hawaii he was more convinced than ever that there would be an attack on the Pacific Coast.

'Can Expect Something'

"It is not at all impossible that we would either have sporadic raids or a concentrated attack on this coast," he warned. "When that happens it will be too late to prepare for it; we must prepare now.

"The Japanese have been awfully quiet recently and we can well expect something."

He expressed satisfaction at the progress that had been made by the civilian defense organizations, particularly the emergency medical services since his visit here a year ago.

"I think that you are as well prepared as you can be without having experienced an actual raid," he declared.—Pasadena *Star-News*.

Doctors' Households Urged to Set an Example in Waste Fat Salvage

The importance of saving waste household fats in order to salvage their glycerine content should be apparent to every physician. The doctor's kitchen, like that of every other family in town, can supply at least a tablespoonful of fat a day—from meat drippings, from rendered trimmings or fat skimmed from the soup kettles and no longer good for food. If that much were retrieved in every household and taken to the meat stores which collect the fat for the renderers, the amount saved would exceed the national goal of 200,000,000 pounds for 1943.

Why must we go to this trouble, in a land where more than a billion pounds of fat used to be wasted every year down the kitchen drain or into the garbage can? Because glycerine is desperately needed to feed the United Nations' war machine, and because many of America's outside sources of fats and oils have been cut off by the war.

Glycerine is indispensable in the manufacture of munitions, because it is the source of both nitroglycerine and dynamite, the first of which provides the explosives for propellants, and the second the means of military demolition. Tanks, ships and planes last longer because of paints containing glycerine. It is used as an anti-icing fluid for the propellors of fighter and bomber planes. The shock absorbers of jeeps and half-tracks, the recoil mechanisms of big guns and the firing mechanisms of depth bombs all contain glycerine.

Glycerine has an important place on the medical front, too, in both war and peace. It is one of the best known and widely used medical materials. There is scarcely a branch of therapeutics in which glycerine does not play a part. An average of more than three pounds of glycerine per hospital bed per year is used in our American hospitals. And an analysis of 15,063 prescriptions made prior to the war in a single American city showed that, with the sole exception of water, glycerine was the most-used liquid ingredient.

In military medicine the rôle of glycerine continues to grow. Even before we entered the war, large quantities of glycerine were shipped by the American Red Cross to England. In the requests made to organized medical groups in the United States for medical supplies, British authorities rated glycerine as equal in importance to surgical instruments.

Practically all the liquid sulfonamides call for glycerine. The war has given increased emphasis also to the long-established value of glycerine itself in burn therapy and surgical treatment, as well as for wound dressings. Dressings can be changed with less discomfort to the patient when they are soaked with glycerine.

The War Production Board is urging all Americans everywhere to help save the fat from which this precious liquid is made. The meat dealer from whom you purchase food will be glad to pay the prevailing rate for the kitchen fats YOUR household conserves. The pennies will buy War Stamps—and every pound of waste cooking fats turned in will provide enough glycerine to make a half-pound of dynamite or four 37-mm. anti-aircraft shells, or their equivalents in other badly-needed materials. Doctors, set an example in your community: start YOUR household saving waste kitchen fat today!—*Bulletin of Waste Fat Saving Committee.*

Veteran Hospital Plans Being Laid

Vast Building Program Mapped to Give All Who Saw War Service Free Medical Care

Washington, April 5.—Rough outlines for a program of hospitalization for veterans of the present war already are being sketched, Federal sources revealed today.

Studies to provide statistical foundation for a vast construction program have been begun as the result of broad legislation recently enacted by Congress assuring government-financed medical care for all persons—men and women alike—serving in the armed forces during the current conflict.

The new law, approved by President Roosevelt three weeks ago, assures the most generous treatment to American war veterans. Chief effect is to grant hospital privileges without regard to service connection for disability and to remove any sex discrimination.

Women Included

Manpower shortages, limitations on construction and lack of funds may delay the new program for many months, perhaps years. Yet steps are being taken to develop hospital facilities.

Under the measure, all hospitalization, clinical treatment and domiciliary care now available for veterans of World War I will be extended to any person in the military or naval service between Dec. 7, 1941, and the termination of hostilities. The statute specifically includes members of the "Waacs," "Waves," "Spars" and Marine Corps Women's Auxiliary.

Facilities Listed

As an emergency measure, the Veterans' Administration has notified all neuropsychiatric hospitals on the East and West Coasts they may exceed their rated capacity by 10 per cent in order to provide a limited amount of immediate treatment to servicemen suffering from mental disabilities incurred in the present war.

A recent survey shows that of a total of 2,446 beds in the General Hospital at Los Angeles, the Army has leased 1,004 and 400 cannot be used because of the manpower shortage. In the domiciliary quarters at Sawtelle only 1,977 of 3,346 beds are occupied now but the remaining facilities have been evacuated because of war conditions. At the San Fernando Tuberculosis Hospital occupancy during February averaged 349 of 364 available beds.—Los Angeles *Times*, April 6.

COMMITTEE ON HOSPITALS, DISPENSARIES AND CLINICS

Resolution: Concerning Closer Coöperation between California Physicians' Service and Blue Cross Hospitalization Groups

The following was presented by the Resolution Committee to the members of the Association of California Hospitals, and unanimously passed February 25, 1943, in the meeting at Oakland, California.

WHEREAS, The present value of the voluntary hospital system in California will be maintained only through a widespread comprehensive and economical system of voluntary financing including Blue Cross Hospital Service plans, and

WHEREAS, The Blue Cross Plan Approval Committee of the American Hospital Association has recommended that Blue Cross plans "consider the possibility of expanding their services by merger with other Blue Cross plans which might serve their respective areas more effectively;" be it

Resolved, That the Association of California Hospitals go on record as approving and urging any steps

taken toward the merger of existing California Blue Cross plans to more effectively serve the citizens of the State of California; and further

Resolved, That it empower the Board of Directors of the Association of California Hospitals to confer with the existing California Blue Cross plans and the Blue Cross Hospital Service Plan Commission of the American Hospital Association towards obtaining this objective; and

WHEREAS, The public desires a service contract which includes both hospital and medical service care during hospitalization; and

WHEREAS, The success of both Hospital and Medical Service plans is dependent upon close coöperation between Physicians and Hospitals; therefore be it

Resolved, That all possible steps be taken to cement a close relationship with California Medical Association and California Physicians' Service to the end that a unified service be made available to the citizens of California; and further

Resolved, That a copy of this resolution be sent to the California Medical Association, California Physicians' Service, the three California Blue Cross Plans, the Hospital Conferences and to the Hospital Service Plan Commission of the American Hospital Association.

Medical Body Backs Hospital Fund Drive

To supply 800 more beds in over-crowded nonprofit hospitals, the Los Angeles County Medical Association is supporting the United Hospital Fund Campaign to raise $3,000,000.

Dr. E. Vincent Askey, president of the Association, states that there are only about half enough beds for residents of the city. Institutions entering into the drive include the Hollywood Presbyterian, Queen of Angels, St. Vincent's, Good Samaritan, California Lutheran, Methodist, and White Memorial Hospitals.—Hollywood *Citizen-News*, April 27.

United Hospital Fund of Los Angeles

The letter which follows was recently sent by the Directors of the United Hospital Fund of Los Angeles, to the physicians of that city:

(COPY)

Dear Doctor:

You are well aware of the acute shortage of beds in the voluntary hospitals in Los Angeles. This condition has been serious for several years. Now it is so critical it compels action. Unless steps commensurate with this need are taken now, our situation will grow increasingly desperate. There are no indications that in the future demands for hospital service will decline.

During the last five years, the population of Los Angeles has increased by 285,000. During the same time only 264 beds were added in our voluntary nonprofit hospitals. Assuming that our hospitals had sufficient beds to accommodate our population in 1937, and including the beds added since then, we would still need 591 more beds than we have to serve our increased population alone based on the recommended ratio of three general hospital beds per 1,000 population.

This is a situation which bears directly upon the health and safety of every Los Angeles resident. It is a problem in whose solution each one of us must share responsibility. But the need for increasing the capacity of our hospitals is of far greater interest and import to the members of the medical staffs of these institutions than to anyone else.

The reasons for this are obvious. Let us examine a few.

First. Medical men, being in daily contact with hospitals, see how desperate the shortage of beds is. The man in the street is aware of the problem only when one in his family seeks admittance to a hospital, while you are confronted with the problem of bed shortage daily in the normal pursuit of your profession.

Second. Because of your training and your keener appreciation of what adequate hospitals mean in the proper treatment of the sick and injured, you, more than anyone else, have an intellectual and moral obligation to assume leadership in any program for hospital improvement.

Third. While the average citizen has but an academic interest in hospitals, as he has in other cultural and welfare institutions, medical men have a heavy professional stake in their proper maintenance. It is true that our hospitals could not well operate without their medical staffs, but it is equally true that progressive doctors cannot practice good medicine without proper hospitals. Each is essential to the other. The hospital is the medical man's workshop.

After carefully analyzing the factors contributing to the inadequacy of our voluntary hospitals, exploring all the possibilities for overcoming these, and taking every possible step to increase the capacity of the plants as they now exist, a committee representing the boards of directors, the medical staffs and the administrators of eight voluntary hospitals have recommended a course of action which they feel to be the only solution to this problem. This solution calls for an intelligent presentation of the facts concerning our hospitals to the public, accompanied by a campaign for funds to enlarge these institutions.

For the purpose of this campaign, a corporation known as the United Hospital Fund of Los Angeles has been formed. The following institutions are members: California Lutheran, Good Samaritan, Methodist, Monte Sano, Hollywood Presbyterian-Olmsted Memorial, Queen of Angels, St. Vincent's and White Memorial.

The immediate goal of this fund-raising effort will be $3,000,000. This campaign will be the inaugural part of a long-range program, whose final objective will be the providing of hospital facilities for Los Angeles in keeping with the size of the community and the needs of its citizens.

The hospitals participating in this campaign will share in the results according to the following ratio which is based on their total average daily census for 1942:

Hospital	*Total Average Daily Census*	*Allocation*
California Lutheran	279.81	$450,000
Good Samaritan	308.0	630,000
Methodist	190.5	300,000
Monte Sano	51.2	87,000
Presbyterian	234.7	372,000
Queen of Angels	236.6	459,000
St. Vincent's	228.0	393,000
White Memorial	173.8	309,000

Contributors to this fund may designate the institution or institutions to receive their gifts. All gifts are deductible for income tax purposes.

Each hospital participating in the United Hospital Fund has submitted to the executive committee of the corporation, the objectives it hopes to realize with its portion of the funds raised. These include additional beds for general use, maternity beds, nurses' training schools, more clinical facilities and renovations to buildings and equipment. While the hospitals may deviate from these objectives, the fact that a joint committee has discussed the over-all improvement programs of the various insti-

tutions augers for a better coördinated hospital plan for Los Angeles in the future.

In this campaign, public-minded citizens of means, business and commercial houses, and corporations will be asked to contribute, in accordance with their interest in the community and their ability to give.

Because the men who use these hospitals are not only the best informed of the need, and because of their great professional equity in them, we feel that to succeed this project must first have the unqualified coöperation and support of the medical staffs. For these reasons we are now seeking your assistance.

With your intelligent leadership and generous financial support mobilized, this project can then be presented to the public with assurance of success.

Within a short time you will be given an opportunity to discuss this program at a meeting of your staff.

Plans for the solicitation of medical staff members will be initiated soon. Thereafter the appeal will be carried to business houses, corporations and selected individuals. We hope to have this fund-raising effort terminated by the end of June.

An undertaking of this magnitude will bring forth many problems—but none which cannot be solved with the full coöperation we know you will give.

Very truly yours,

DIRECTORS OF THE UNITED HOSPITAL FUND

Ritz E. Heerman, *Secy.*	Dr. Walter M. Holleran
Paul C. Elliott, *Treas.*	J. Frank Holt
W. L. Bradway	Otis A. Hudson
Howard Burrell	Roland Maxwell
G. H. Curtis	W. A. Monten
Colin M. Gair	Rt. Rev. Thos. J. O'Dwyer
Judge R. Morgan Galbreth	J. Howard Ziemann

By Th. R. Knudsen,
President, United Hospital Fund of Los Angeles.

San Francisco Hospitals

(As Seen "Behind the News," with Arthur Caylor):

Already, throughout Southern California, the hospital shortage is "desperate." Many sick people can't get beds. Increasingly, women are expected to have their babies in the Indian manner under a huckleberry bush—a system of self-service which antedates the cafeteria even in the Sunny South.

In this pinch, Los Angeles County's general hospital is preparing to take in pay patients—which is revolutionary—and Superintendent of Charities, Arthur J. Will has asked a Federal grant of $194,000 under the Lanham Act for 600 beds and 100 bassinets. He has a committee, which includes doctors, working on a plan to let pay patients be treated by private physicians—or by staff physicians under a scheme whereby the money would be used for research.

San Francisco is watching the Los Angeles experiment, my agents report. San Francisco Hospital could be expanded by 200 beds, according to Health Director Geiger. A big maternity ward could be established. Another 500 beds could be installed at Laguna Honda Home. But San Francisco apparently is waiting for the situation—and it's Wills who calls it "desperate"—to get equally bad here.

If that happens and it then develops that Uncle Sam acts with regard to hospitals at the same speed he has applied the Lanham Act to child nurseries, the theme song is likely to be that part of "Casey Jones" which runs: "Gonna get to Frisco but we'll all be dead."

Dr. Geiger frankly would like to avoid the complications sure to follow if pay patients are admitted to San Francisco Hospital. In the back of his mind has been the hope that San Francisco Hospital might do its part by taking the charity load off private hospitals. But information is that the private hospitals already are carrying a minimum of charity patients. Hence it appears possible that, before long, the Los Angeles system will be forced upon San Francisco—willy nilly. . . . —San Francisco *News*, March 12.

COMMITTEE ON HEALTH AND PUBLIC INSTRUCTION

Extra Food Rations for Patients

In the April issue of California and Western Medicine, on page 216, brief editorial comment was made concerning Ration Order 13. The May number of the *Bulletin of the San Francisco County Medical Society* gives additional information and prints a form blank for a physician's statement, the use of which will save time for members of the medical profession and their patients. Explanatory statement and copy of form blank follow:

(Explanatory Statement)

Since the institution of food rationing, there has been some confusion in the matter of obtaining extra rations for patients requiring more than the regular allotment of foods.

Extra rations for patients on special diets are provided for by the Office of Price Administration Ration Order 13, article II, section 2.5, which is reprinted below.

The food rationing program is in its infancy and the lack of exact knowledge of the procedure necessary to obtain special rations has resulted in many incomplete and unsatisfactory requests being submitted to the ration boards. Likewise, the ration boards are faced with the problem of passing upon food requests based upon medical needs. In the attempt to produce a mutually satisfactory arrangement to facilitate the equitable distribution of extra rations to the proper patients, the San Francisco County Medical Society has appointed a committee to work with the San Francisco ration boards.

Your Society is printing a form (approved by the OPA, reproduced on page 9, designed to save the physician's time in prescribing extra food. This will make certain that all the essential information is presented. *The patient or his representative will be supplied this form at the time he calls at his local board for his regular extra ration application R-315.*

Ration Order 13, article II, section 2.5, reads as follows:

Consumers who need more processed foods because of illness may apply for more points. (*a*) Any consumer whose health requires that he have more processed foods than he can get with War Ration Book Two may apply for additional points. The application must be made, on OPA Form R-315, by the consumer himself or by some one acting for him and may be made in person or by mail. The application can be made only to the board for the place where the consumer lives. He must submit with his application a written statement of a licensed or registered physician or surgeon showing why he must have more processed foods, the amounts and types he needs during the next two months and why he cannot use unrationed foods instead.

(*b*) If the board finds that his health depends on his getting more processed foods and that he cannot use or cannot get unrationed foods, it shall issue to him one or more certificates for the number of points necessary to get the additional processed foods he needs during the next two months.

The application form referred to, OPA Form 315, is apt to be somewhat confusing to patients. It is titled "Sugar Special Purpose Application" and was developed primarily to meet the need for home canning. It is being used temporarily, until a more adequate form can be developed. The procedure indicated in section 2.5 may be changed somewhat in the future, in which case due notice is to be provided.

* * *

(Form Blanks for Patient and Physician)

Consumer's Application for Additional Foods to Be Filed At Local Rationing Board

Consumer's Request to His Physician

The undersigned consumer and patient hereby requests his physician to prepare and execute the following statement to be filed with the consumer's application (OPA Form R-315) to his Ration Board for additional ration points:

....
(Signature of patient) (Address of patient)

.....
(Signature of patient's agent)

.....
(Address and relationship of agent, if any)

* * *

Physician's Statement

The undersigned.....is a licensed
(Print name of physician)
physician or surgeon.

....., aged about.....
(Print patient's name)
years, has been under my care for about.....
(Specify period)
and requires additional foods because such patient is suffering from.....
(Nature of illness)

I estimate that the amount and types of foods required by said patient each week for the next two (2) months is as follows: (Specify quantity of each food by weight and *specify alternate foods* for each food.)

(Insert items here)

Said patient cannot use any other foods for the following reasons:

(Insert reasons here)

....
(Signature of Physician) (Office address)

....
(Date) (Telephone number)

* * *

Advisory Medical Committee's Findings

The undersigned members of the Advisory Medical Committee have examined the patient's application for additional foods and the foregoing physician's statement and find as follows:

.....
.....
.....
.....
(Advisory Medical Committee)

Note: Rationing Regulations do *not* permit granting additional allotments of *coffee* to consumers for medicinal or other reasons.

The Physicians' Part in Food Rationing

The Bulletin of the Los Angeles County Medical Association, in its issue of May 6, 1943, also gave information concerning O.P.A. Ration Order 13:

To Members of the Los Angeles County
Medical Association:

The advent of food rationing has placed upon the medical profession the serious responsibility of prescribing food for persons, who, by reason of impaired health, must have more food than their allotment of ration points permits them to purchase. Within a few days after rationing began it was apparent that physicians, the public, and rationing boards alike were confused as to procedure. The Los Angeles Office of Price Administration therefore requested the Los Angeles County Medical Association to designate a committee of physicians who might both assist in clarifying procedure and advise rationing boards regarding prescriptions which seemed to them improper.

The provisions governing the prescribing of additional rationed foods appear in OPA Ration Order 13, Sec. 2.5 for "processed foods" and Ration Order 16, Sec. 2.4 for "meats, fats and oils." The provisions were identical, except for the reference to "foods covered by this order" and read as follows:

"Consumers who need more foods covered by this order because of illness may apply for more points.

"a. Any consumer whose health requires that he have more foods covered by this order than he can get with War Ration Book Two, may apply for additional points. The application must be made on OPA Form R-315, by the consumer himself or by someone acting for him, and may be made in person or by mail. The application can be made only to the board for the place where the consumer lives. He must submit with his application a written statement of a licensed or registered physician or surgeon, showing why he must have more foods covered by this order, the amounts and types he needs during the next two months, and why he cannot use unrationed foods instead.

"b. If the board finds that his health depends upon his getting more foods covered by this order, and that he cannot use or cannot get unrationed foods, it shall issue to him one or more certificates for the number of points necessary to get the additional foods covered by this order which he needs during the next two months."

A letter should be addressed to the patient's local rationing board. The following information must be given:

1. The name and address of the patient, and a statement that the patient is being treated or observed by the physician signing the request.

2. That in the course of such treatment or observation it is found that the patient must have more "processed foods" or more "meats, fats or oils," or more of both, than he can obtain with his regular ration book.

3. A detailed statement of the amount of "processed foods" or "meats, fats, and oils," or both, including the kind and weight of each type of food required for the patient's exclusive use for a maximum period of two months, in excess of the amount obtainable under the patient's ration book. Should the patient be permitted to choose from a variety of foods, such as meats, the physician may compute the necessary number of extra points needed, or express the need in terms of pounds needed for the two-month period. It is better to express the need for vegetables and fruits in pounds rather than in cans because of the variation in can sizes.

4. An explanation in detail as to why the patient must have more rationed foods for his health.

5. Why he cannot use unrationed foods instead.

6. An estimate of the probable duration of the patient's illness.

7. If an emergency, so state.

Physicians should inform themselves as to the kinds of food which are and which are not rationed. For example, the protein and fat requirements of a diabetic may be met in part by poultry, fresh fish, cottage cheese or cream cheese, which are not rationed at present. Processed foods, including canned fruits and vegetables, should not be prescribed unless an excellent reason exists for not using fresh foods.

Patients may request prescriptions for processed foods on the ground that they do not have time or facilities to prepare and cook the fresh product. In such instances, the doctor should state the facts on his prescription and allow the rationing board to decide whether the contention is valid. He should limit his own recommendation to the purely medical aspects of the case.

It is expected that one or more physicians in each area will be designated to act as advisors to rationing boards, in instances where prescriptions seem unreasonable, excessive, or unnecessary.

It is not the intention of the undersigned to advise any physician as to the kind or quantity of food which he should prescribe for any diseases or for any patient. Great pressure may be placed upon doctors by demanding and selfish patients who have no real need for additional rationed food. We suggest that such people be told that the food situation is serious, and that common decency as well as the OPA regulations make it quite impossible to prescribe extra food, unless a real and urgent medical reason exists.

COMMITTEE ON FOOD RATIONING,
HOWARD WEST, M. D.,
CARL HOWSON, M. D.,
E. T. REMMEN, M. D., *Chairman.*

Self-Protection Against Tularemia ("Rabbit Fever")

The following has been adapted by the Department of Health of the City of Los Angeles from the New York State Health News:

With the shortage of meat, it is likely that wild rabbits will be used for food more than usual this year. Since contact with wild rabbits gives rise to a certain risk of acquiring the disease tularemia, or "rabbit fever," hunters, housewives, chefs, and others who handle them, should again be reminded of the simple precautions which will guard against the infection. The following precautionary measures are suggested:

1. Leave the too-easily secured rabbit alone. If a rabbit is an easy shot, the chances are it is ill, and may be infected with tularemia.

2. Do not clean the rabbit if you have any sores, cuts or other lesions on your hands. Even if you have no lesions, it is well to wear rubber gloves when cleaning the rabbit and to wash the gloves thoroughly with soap and hot water before taking them off. Infection is usually acquired through contact with the blood or internal organs of rabbits and in almost every case which has occurred thus far in New York, there is a history of a cut or other lesion on the hand through which the infection apparently penetrated.

3. Be careful in the process of cleaning the rabbit not to cut yourself with the knife, puncture a finger on a broken rib, or in some other way cause a break in the skin.

4. Cook the rabbit meat thoroughly. The infection can be acquired by eating insufficiently cooked infected rabbit meat.

This warning is not intended to discourage the hunting of rabbits nor the use of rabbit meat. Such hunting is good sport and the meat obtained is a nutritious supplement to the diet, particularly valuable at this time of meat shortage.

The chance of acquiring tularemia from domestic rabbits is extremely small. For absolute safety, however, it would be good policy to follow the same precautions listed above.

A Venereal Disease Program

Recommendations for a Venereal Disease Control Program in Industry which follow, are from a Report of the Advisory Committee on the Control of Venereal Diseases, Otis L. Anderson, Chairman:

In order to assemble current authoritative information and to formulate basic principles applicable to a program of venereal disease disease control in industry, the Surgeon General has appointed an Advisory Committee to the United States Public Health Service. This committee has outlined the objectives of such a program as:

A. Medical and Public Health:

1. To find and refer for proper medical management all cases of venereal diseases among workers in industry.
2. To establish equitable policies for the employment of applicants and continuation of services of employees who have venereal diseases.
3. To coördinate the community and industrial venereal disease control programs.

B. Employee:

1. To improve the physical condition of employees.
2. To reduce the number of workdays lost through illness or injury.
3. To provide job placement.
4. To prolong and increase the earning power of employees.

C. Employer:

1. To reduce compensation costs.
2. To lessen work interruptions and labor turnover.
3. To enhance production by increasing the efficiency of workers.
4. To minimize personnel problems.

In order to assure agreement on all phases of fundamental policy, the committee recommends that certain agencies be consulted in carrying out this program: the State labor department, industrial commission or similar department of State government; the appropriate committee of the State medical society; the association representing employers; the labor organizations; appropriate voluntary health and welfare associations.

Responsibility for the administration of the program should be shared by the industrial hygiene and venereal disease divisions of the State health department. The program should not be inaugurated without a complete educational program. The employee should be convinced that adequate treatment protects both his health and his ability to earn a living, and the employer that not all cases of venereal disease are infectious, through an educational program before venereal disease control measures are introduced.

In order that the control program may be effective, preemployment examinations should be mandatory for all workers. Laboratory tests for syphilis and gonorrhea should be made a part of the periodic, reemployment or "return from illness" physical examinations which are the policy of the industry. The interval between examinations should under no circumstances be more than three years.

It is of utmost importance that the results of the medical examination be considered confidential between the worker and the medical staff. Information should be furnished to others only with the consent of the individual concerned or, failing this, on legal advice. The medical staff should make proper recommendations to the management as to the physical fitness of the employee for work. When the usual clinical record is kept in an open file, venereal disease forms should be filed in the medical department for the use of the medical staff only.

There is no reason for denying employment to an applicant or for discharging an employee because an examination has revealed evidence of syphilis or gonorrhea, provided:

1. That the employee agrees to place himself under competent medical management;

2. That, if the disease is in the infectious stage, employment should be delayed or interrupted until such time as a noninfectious state is established through treatment and open lesions are healed;

3. That when syphilis exists in a latent stage, employment should not be delayed nor interrupted;

4. That employment may be deferred or denied when the individual is an industrial hazard;

5. That occupational readjustments of employees be made of individuals developing disabling manifestations;

6. That workers with syphilis in any of its stages be excluded from areas where there is exposure to chemicals which may produce toxic reactions, and those having cardiovascular syphilis or neurosyphilis should not be exposed to physiologic stresses;

7. That workers with gonorrhea should be allowed to work only under special medical observation during the administration of sulfonamide drugs.

The applicant or the employee whose examination reveals evidence of a venereal disease should be called to the industrial physician's office for a conference. He should be instructed as to the nature of the disease which he has in order that he may coöperate intelligently with the requirements of the program. He should be referred to a reputable source for medical attention and be furnished with a letter directed to his physician stating the results of the examination and what is expected of the employee as to regularity of treatment if he is to be employed. The industrial physician should receive a record of treatment at about monthly intervals. The names of individuals who have neglected or refused treatment should be turned over to the health department for appropriate action in bringing them back to treatment.

The plant physician making a tentative diagnosis of communicable syphilis or gonorrhea should without delay acquaint the appropriate health authority with the facts.

Caution Concerning Substitutes for Glycerine

UNITED STATES DEPARTMENT OF AGRICULTURE
Food Distribution Administration

Washington, D. C., April 6, 1943.

To All Consumers of Glycerine:

The present shortage of glycerine and the necessity of issuing available supplies for essential war needs has made it necessary to deny the use of glycerine in many instances. Many former users of glycerine, who are now unable to secure supplies, are using substitute materials where they are available.

In a recent memorandum addressed to all consumers of glycerine we discussed the reasons for our inability to allocate glycerine to all uses, as well as the methods for obtaining glycerine for approved end uses. We also mentioned in this memorandum the need of working out substitutes where possible. In using substitutes all consumers must investigate the toxicity of the substitute since it is an established fact that certain substitutes are definitely toxic. Among these toxic substitutes are:

Ethylene glycol
Diethylene glycol (diglycol)
Carbitol
Polyethylene glycol

and under no circumstance should these or other toxic substitutes be used in any product whether food, drug or cosmetic which is likely to be taken internally or otherwise absorbed by external application.

Furthermore, a number of proprietary glycerine substitutes have been offered for sale and before using them, inquiry should be made of the manufacturer in order to determine whether or not any of the above compounds or other toxic substitutes are present. When in doubt as to the use of any of these substitutes in food, drug, or cosmetic preparations, inquiry should be made of the authorities in charge of administering the Food, Drug and Cosmetic Law.

R. W. CAPPS, *Acting Chief*,
Fats and Oils Branch.

COMMITTEE ON MEMBERSHIP AND ORGANIZATION

Proposed Medical Liaison Office in Washington, D. C.

The letter and proposed resolution which follow, to be presented to the House of Delegates of the American Medical Association when it convenes in Chicago on June 7, 1943, may bring out much interesting discussion:

(Letter)

NATIONAL CONFERENCE ON MEDICAL SERVICE

April 8, 1943.

Dear Doctors:

Most medical society officials are well aware of the fact that extraordinary measures must be taken at once by organized medicine in the United States if the present high standards of medicine are to be maintained. The destruction of these standards will be a serious blow first of all to the general public and, secondly, to the medical profession. We are American citizens, the same as other groups, and we have a right to be represented and a right to be heard before any such steps are taken by those in whom constitutional authority is vested.

It is generally agreed that foremost among these extraordinary needs is a liaison office in Washington that will be in a position to offer timely, courteous and courageous advice and medical counsel to those whose duty it is to consider such matters. We have been repeatedly advised by men who are in a position to know that such advice will be welcomed. Such an office will bring the American Medical Association, as the representative of the medical profession of this country, in a much closer contact with official Washington than ever before. This will serve to protect both the patient and his physician from ill-advised political and economic experiments which ought not to be inflicted upon either the sick or the medical profession, either in time of war or in time of peace. . . .

The need for such an office that will be truly representative of the medical profession of this country has impressed itself upon medical men from every corner of the Union and the National Conference on Medical Service, which was held in Chicago on February 14, last, and

which Conference was made up of leaders in the medical profession from 29 states. . . .

All of us should be mindful that neither men nor time remain stationary. Either we go forward or we go backward. This is 1943 and the situations that confront us today are vastly different from those that confronted us twenty-five years ago. It should be noted in this connection that both the American Dental Association and American Hospital Association have decided to establish offices in Washington because they too appreciate that a mere official expression of principles will have little effect. Intelligent and authorized representatives of American medicine should be stationed there at all times, not only to give the advice that is so sorely needed but also in turn to be able to report to the medical profession of this country the activities of official Washington. At the same time we can keep a watchful eye on that other little group which expends so much of its time advancing the interests of cultism.

To effectuate similar action by the House of Delegates of the American Medical Association, numerous delegates from state societies are now planning to present the printed resolution enclosed with this letter. . . . Please study this resolution carefully and present it forthwith to your own local or state society. The time between now and the June meeting of the House of Delegates of the American Medical Association is short. We sincerely hope that you will submit it promptly to your House of Delegates or Council and that your society will instruct its Delegates to the American Medical Association to support this resolution when offered in June.

Respectfully yours,

W. L. BURNAP, M. D., *President.*
C. L. PALMER, M. D., *Secretary.*

* * *

(Resolution)

A RESOLUTION

To be presented to the House of Delegates of the American Medical Association at its next annual meeting in Chicago in June, 1943, for establishing a Committee on Medical Service.

WHEREAS, The medical profession is conscious of its responsibilities in providing timely and adequate medical services to all of the American people, irrespective of race, creed or financial status, and

WHEREAS, It believes it to be its duty and right to make available scientific facts, data and medical opinion with respect thereto, and to make known the rôle that the science and art of medicine plays in the daily lives of all Americans, and

WHEREAS, The medical profession of the United States is ready to offer constructive leadership in the advancement of medical principles that will further medical service to all of the people, and to preserve, not only the science and art of medicine, but the standards associated with the practice of medicine in America;

Now, Therefore, Be It Resolved, That there is hereby created by this House of Delegates a Committee on Medical Service which shall be composed of the following members:

1. The president of the American Medical Association, ex-officio.

2. The Immediate Past-President of the American Medical Association.

3. The Secretary of the American Medical Association, ex-officio.

4. A member of the Board of Trustees of the American Medical Association, designated and selected by the Board of Trustees.

5. One member of the American Medical Association elected as hereinafter provided from each of the following nine geographical subdivisions of the United States:

New England—Maine, New Hampshire, Vermont, Massachusetts, Rhode Island, Connecticut.
Middle Atlantic—New York, Pennsylvania, New Jersey.
East North Central—Ohio, Indiana, Illinois, Michigan, Wisconsin.
South Atlantic—Delaware, Maryland, District of Columbia, Virginia, West Virginia, North Carolina, South Carolina, Georgia, Florida, Puerto Rico.
East South Central—Kentucky, Tennessee, Alabama, Mississippi.
West South Central—Arkansas, Louisiana, Oklahoma, Texas, Panama Canal Zone.
West North Central—Minnesota, Iowa, Missouri, North Dakota, South Dakota, Nebraska, Kansas.
Mountain—Montana, Idaho, Wyoming, Colorado, New Mexico, Arizona, Utah, Nevada.
Pacific—Washington, Oregon, California, Alaska, Hawaii, Philippines, and Pacific Islands.

The members of this House of Delegates from each of the foregoing geographical subdivisions of the United States shall elect one member of the American Medical Association to serve on said Committee; three of said nine members shall serve for one year; three shall serve for two years; and three shall serve for three years; the respective terms of office of the nine members first elected shall be decided by lot and thereafter the said terms shall be for three years each. The expiration date for the first one year term shall be at the next ensuing annual session, of the House of Delegates of the American Medical Association. Expiration dates for all terms shall coincide with the dates of the regular annual session, of the House of Delegates of the American Medical Association.

Be It Further Resolved, That the duties of the Committee on Medical Service shall be:

1. The making available of scientific facts and data and medical opinion with respect to timely and adequate rendition of medical care to the American people.

2. To integrate the activities of the Committee on Medical Service with respective state and county committees on like activities.

3. Establish relationships and coöperation with other allied groups who are likewise engaged in the rendition of medical care, in its various branches, to the American people.

4. The Committee on Medical Service shall hold at least two meetings per year; one shall be held at the time and place of the Annual Meeting of this House of Delegates; the other meeting shall be held in the City of Washington, D. C., and called at the direction of the Chairman; and such other meetings as may be necessary to be called by the Chairman upon the written request of the majority of the Committee.

5. The Committee shall forthwith and annually thereafter elect from its own membership a Chairman and a Vice-Chairman.

6. The Committee on Medical Service shall establish and maintain an office in Washington, D. C., and shall further be empowered and directed to employ a full-time Executive Director, who shall act as Secretary of the Committee, and, whose duties shall be specified by the Committee. Such Executive Director shall be a physician who has been actively engaged in the private practice of medicine for not less than five years during the previous ten years, and furthermore, be informed and qualified to act as a Liaison Representative of said Committee.

7. The Committee on Medical Service is further authorized to hire such legal and administrative help as is necessary.

Be It Further Resolved, That the Committee on Medical Service shall submit a Budget for its expenses for the fiscal year to the Board of Trustees of the American Medical Association, and it is the consensus of opinion of this House of Delegates that the Board of Trustees shall forthwith appropriate not less than fifty cents nor more than one dollar for each member of the American Medical Association so that adequate funds will be available for such Committee to carry out its work on an honorable and ethical plane in keeping with the standards of American Medicine.

Be It Further Resolved, That this Committee shall submit an Annual Report to the House of Delegates at their Annual Meeting.

And Be It Further Resolved, That this resolution upon its adoption by the House of Delegates shall be forthwith transmitted to the Board of Trustees with the request that the Board of Trustees report back its action to the House of Delegates within twenty-four hours as provided for in the Constitution and By-Laws of the American Medical Association.

Work Suggestions for County Societies

Industrial Health.—Promotion of health among industrial employees is of vital importance at this time as a means of reducing absenteeism in plants producing war materials. The State Association is formulating a program on industrial health activities and will ask each county medical society to coöperate. Here is a big field and a real job for most local societies.

Maximum Utilization of Hospital Facilities

Efficiency Measures.—Although the field of hospital administration is in fact apart from the practice of medicine, still a bad community hospital situation will adversely affect medical and health services. Consequently, it would be wise for representatives of the medical society to coöperate with hospital officials to make sure that all hospital facilities are being utilized as efficiently as possible. Points to be considered in such a plan might include: elimination of "luxury" hospitalization; reduction of the time of hospitalization in certain types of cases; a survey of all beds in all community institutions for the care of the sick to determine if efficiency of utilization might be heightened through readjusting case loads, etc.; fullest possible use of nurses' aides and other lay personnel to release interns and residents and nurses for professional duties.

Increasing Bed Capacity.—In communities where such steps have already been taken the result has been a surprising increase in the availability of hospital facilities. One medium sized community found that it could increase its total bed capacity by more than 300 without purchasing a single piece of additional equipment. It did this by taking beds out of storage, placing additional beds in nonessential hospital floor space, and placing general patients in certain county institutions where the case load had dropped.

Wider Utilization of Nursing Services

It may be possible that the community's practicing registered nurses can assume certain tasks now being done by physicians, such as changing dressings, etc., under their direction, thus reducing demands for physicians' services. In at least one community, the local Red Cross chapter has made available the services of a graduate nurse for this purpose, and she has agreed to render such nursing care wherever it is recommended by the family physician. Close coöperation with nursing organizations should be maintained and their help solicited.

Utilization of Services of Health Department

Coöperation and Coördination.—Coördination of the services of the local health department and the services of the physicians in private practice is of greater importance now than ever. Many health department offices have personnel and facilities which would be extremely useful to the physician, especially if he finds himself swamped. The possibility of seeking the assistance of voluntary health agencies also should be explored.

Each Physician's Personal Obligation

Longer Hours, More Work.—It is obvious that the heavy demands of the armed forces for medical officers must result in greatly increased work for the physicians remaining on the home front. This added burden must be equitably distributed among all the physicians. Every physician at this time must provide all the medical service he is physically able to give. It may be necessary for some specialists to practice a limited amount of general medicine for the duration. It is necessary for physicians who have retired to resume practice and for those who have been devoting a limited amount of time to practice to carry on full working days. Local societies should drive home these points and try to work out means which will result in an equitable division of time and work among all doctors in the county.

Making Up Schedules.—Many physicians can improve the efficiency of their practices and help in conserving the time of patients as well as their own time, if they will do a better job of scheduling patients for office and home calls. For example, with help of his patients, a physician may be able to schedule house calls so he can see all patients residing in a certain section of the city or county in the morning and those in another area in the afternoon. Emergency calls must be made, of course, but certainly confusion in routine calls could be avoided through more efficient scheduling. Moreover, patients should be encouraged to see the doctor in his office whenever possible, thus saving time and providing an opportunity for the physician to make use of the services of his office nurse or attendant.

Miscellaneous Recommendations

Rationing Problems.—The rationing of automobiles, tires and gasoline presents problems which affect the medical and health situation to some extent. Medical and health services will break down unless the physician is provided with means of transportation. The county medical society should represent the medical profession of the county before rationing boards if serious problems arise. This could be done through the Committee on Medical Preparedness or a special committee established for that specific purpose. In bona fide cases of complaint, the county medical society's influence should be used in seeing that satisfactory adjustments are made.

Obstetrical Problems.—In one community the medical society conducted a pregnancy survey as a means of estimating future demands for obstetrical services and maternity beds in the local hospital. It should be a permanent and continuing project of the local medical society to maintain complete and reliable data about the medical resources of the county—hospital facilities and medical personnel. If breakdowns seem imminent, steps to correct the situation should be taken immediately—before the crisis occurs.

Official War Services.—The profession is obligated to assist the government in providing medical advice and services for war agencies such as Selective Service and Civilian Defense. All physicians should participate in these activities. The burden must be equalized. If only a few physicians take on these duties these physicians will not be able to devote sufficient time to their patients. This is unfair to those men and their patients.

Suggestions as to how some of the problems reviewed here might be handled or information as to how they are being met should be transmitted to the Headquarters Office, so they can be passed on to all county medical societies.

Providing civilians with necessary medical and health services is a responsibility of the medical profession under all conditions. Under wartime conditions the job is difficult but it can and will be done. No decrees, no administrative proclamations, no legislation, no compulsion will be necessary to tell doctors how to do the job on the home front, providing medical organizations take the initiative and the individual physician follows through. —*Item from an "Exchange."*

COUNTY SOCIETIES†

CHANGES IN MEMBERSHIP

New Members (49)

Alameda County (4)

Garfield, Sidney R., *Oakland*
MacDonald, James L., *Oakland*
McDonald, Dorothy E., *Berkeley*
Moore, Richard W., *Oakland*

Butte-Glenn Counties (1)

Benninger, Concessa L., *Chico*

Fresno County (4)

Covington, C. H., *Madera*
Downing, William E., *Fresno*
Hof, Elmer A., *Fresno*
Weinberger, Herbert, *Ahwahnee*

Humboldt County (1)

Gianotti, Ernest Fiirst, *Scotia*

Imperial County (2)

Randolph, C. E., *Holtville*
Randolph, Harry L., *El Centro*

Kern County (3)

McNamara, Virginia P., *Bakersfield*
Patrick, Robert, *Bakersfield*
Savage, Emerson P., *Bakersfield*

Kings County (2)

Lees, Floyd E., *Hanford*
Lymp, Leo J., *Hanford*

Los Angeles County (7)

Foulk, Marguerite Lewis, *Los Angeles*
Gerber, Alex, *Los Angeles*
Lee, Henry Yen, *Los Angeles*
Page, Emery Phillips, *Alhambra*
Powers, Harry James, *Los Angeles*
Smith, C. Richard, *Los Angeles*
Swartout, Hubert Oscar, *Los Angeles*

Sacramento County (3)

Hemminger, George W., *Sacramento*
Perry, Herbert B., *Sacramento*
Ziph, Albert, *Sacramento*

San Bernardino County (2)

Heeres, Peter S., *Ontario*
Sterling, Allen F., *San Bernardino*

San Diego County (4)

Howell, William L., *San Diego*
Isham, Charles A., *San Diego*
Nelson, Max, *National City*
Oster, William B., *Ocean Beach*

San Francisco County (3)

Poulson, Theodore S., *San Francisco*
Sherman, Jr., Robert S., *San Francisco*
Tanner, Owel Ralph, *San Francisco*

San Joaquin County (2)

Fife, William S., *Detroit, Michigan*
Gale, Lester S., *Stockton*

San Luis Obispo County (1)

Bauer, Herbert, *San Luis Obispo*

Santa Barbara County (3)

Helbling, Franklin K., *Santa Barbara*
Olsen, Arthur R., *Santa Barbara*
Shorkley, Genevieve, *Carpenteria*

Santa Clara County (1)

Rehm, Mary Hoag, *Bethesda, Maryland*

Stanislaus County (3)

Maino, C. R., *Modesto*
Morrison, Alan F., *Oakdale*
Sherertz, Richard Charles, *Modesto*

Ventura County (1)

Nash, L. R., *Camarilla*

Yolo County (2)

Gray, John E., *Woodland*
Parsons, James E., *Dixon*

Transfers (11)

Jackson, Josephine A., from San Diego County to Los Angeles County
London, Milton Z., from Los Angeles County to Alameda County
Mann, Allan I., from Los Angeles County to San Diego County
Porter, Langley, from San Francisco County to Santa Barbara County
Wallace, John A., from Imperial County to San Bernardino County
Wilkinson, A. J., from San Diego County to Ventura County
Wright, Virginia L., from San Joaquin County to Lassen-Plumas-Modoc County

Retired Members (1)

Rowell, Hubert N., *Alameda County*

† For roster of officers of component county medical societies, see page 4 in front advertising section.

In Memoriam

Fleming, Ernest William. Died at Los Angeles, March 7, 1943, age 81. Graduate of the University of Michigan Medical School, Ann Arbor, 1885. Licensed in California in 1889. Doctor Fleming was a retired member of the Los Angeles County Medical Association, the California Medical Association, and an Affiliate Fellow of the American Medical Association.

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Hambleton, Marcus Philip. Died at San Bernardino, March 16, 1943, age 63. Graduate of the Bowdoin Medical School, Brunswick-Portland, 1903. Licensed in California in 1921. Doctor Hambleton was a member of the San Bernardino County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

OBITUARIES

Frank Roscoe Makinson
1885—1943

Frank Roscoe Makinson was born on a farm in Kansas, near the little village of Cedar, on September 1, 1885. There he was reared, alternating his time between school and farm until completing his high school studies.

As is the case with many farmer boys, farm and animal husbandry held no interest for Frank and he chose to follow the earlier occupation of his mother, who was an educator of other people's children before she concentrated her attention upon the rearing of her own group of nine, of which he was the youngest.

He graduated from the Kansas State Teachers' College and taught school for a short time. But another field called him. In Kansas he began premedical studies. These were interrupted for a short time by his coming to California, where they were resumed. Here he entered the Oakland College of Medicine and Surgery, where he graduated in May, 1913. At last his greatest ambition had been achieved, but his studies were far from complete. Inspired by the very enthusiastic faculty of the small medical school, the young graduate in medicine entered the hospital of the Sisters of Providence in Oakland, where he remained for a little more than three years before opening an office and entering private practice. Thus progressed Frank's long apprenticeship in the science and art of medicine which, properly, begins with one's premedical studies, continues through medical school and hospital, and extends to the evening of the last day of a doctor's professional career. During all of this period of active practice, he learns from book and scientific magazine, from great teachers and clinicians, from patients high in the affairs of men, as well as from the sick poor in the midst of their circumscribed opportunities and meagre surroundings.

All of these methods of study were followed with avidity by Dr. Makinson. Enthusiastic in the study of his chosen profession, he never sold the treatment of disease as merchandise.

He belonged to the county, state, and national medical associations, the California Academy of Medicine, and was a Fellow of the American College of Surgeons.

His interests were:—first, his family; next, his medical practice, and then he gave his remaining time and energy to the affairs of the medical profession itself.

In his service to medicine many honors—unsought—came to him: President and Councilor of the Alameda County Medical Association; President of the Public Health League of California; Councilor of the C.M.A. from the Seventh District (Alameda and Contra Costa counties); Chairman of the C.M.A. Committee on Public Health Education.

The arduous, time-consuming effort as Chairman of this highly important Committee began in 1940 and the final report of its activities he wrote during his last illness, bringing to a successful close a very important and laborious educational program.

During all of these activities he was the Medical Historian of the Alameda County Medical Association and gathered together much biographical data on the pioneers of our Association, as well as upon those who have passed our way in the intervening years.

What Dr. Makinson did for medicine was performed quietly, without fanfare or gesticulation and without any claim, expressed or implied, for reward or acknowledgment.

His devoted wife, Alice Bouchet, who was his right hand; a daughter, Mrs. Shirley Makinson Greig, and a son, James Thurston Makinson, M.D., recently graduated from the George Washington University Medical School and presently interning in Passavant Memorial Hospital in Chicago, survive him.

The gathering of friends, patients, and colleagues at his obsequies attested to the respect and affection in which he was held.

Perhaps if these attendant people could have given voice to their thoughts, they would have echoed the words of Steele written so many years ago: "There is not a more useful man in the commonwealth than a good physician; and by consequence, no worthier person than he that uses his skill with generosity, even to persons of condition, and compassion to those who are in want."

DANIEL CROSBY.

* * *

The esteem in which Doctor Frank R. Makinson was held is further evidenced by the resolution passed by the Assembly of the California Legislature in session at Sacramento, on April 23, 1943, and the action of the State Assembly in adjourning in his memory.

Assembly Resolution follows:

Resolution

The following resolution was offered:

By Messrs. Johnson, Carlson, Carey, Dickey, Sheridan, and Dunn:

House Resolution No. 207

Relating to Dr. Frank R. Makinson

WHEREAS, Dr. Frank R. Makinson of Oakland, came to his death on April 17, 1943; and

WHEREAS, Following his graduation from the Oakland College of Medicine and Surgery, Dr. Makinson devoted himself to the practice of medicine in Oakland for 30 years, was honored as a Fellow of the American Medical Association and of the American College of Surgeons, became President of the Alameda County Medical Association, and at the time of his death was a member of the Council of California Medical Association, representing Alameda County; and

WHEREAS, Dr. Makinson is survived by his widow, Alice Makinson, by a daughter, and by a son who is just finishing medical school; and

WHEREAS, It is the wish of the members of this Assembly by this resolution to give recognition to the distinguished service of Dr. Makinson to his community and to his profession, and to express their sympathy to Dr. Makinson's widow and two children; now, therefore, be it

Resolved by the Assembly of the State of California, That when this Assembly today adjourns it do so out of respect to the memory of Dr. Frank R. Makinson; and be it further

Resolved, That the Chief Clerk of the Assembly is requested to transmit suitably engrossed copies of this resolution to the family of Dr. Frank R. Makinson.

Request for Unanimous Consent

Mr. Johnson asked for, and was granted, unanimous consent to take up House Resolution No. 207, at this time, without reference to committee.

Resolution read and adopted by a rising vote of the Assembly.

• • •

Adjournment

At 11:43 p.m., on motion of Mr. Sam L. Collins, the Speaker declared the Assembly adjourned until 9:30 a.m., Saturday, April 24, 1943, out of respect to the memory of the late Dr. Frank R. Makinson.

C. WILLIAM QUEALE, Minute Clerk.

✤

Margaret Schulze
1894-1943

On Sunday, February 14, 1943, death claimed Dr. Margaret Schulze, well known to this community as an able and conscientious woman who had become a gynecologist of national prominence, a talented member of the faculty of the University of California Medical School, a distinguished member of our Medical Society, a Fellow of the Pacific Coast Gynecologic Society, a Fellow of the American College of Surgeons, and a member of the American Board of Gynecology and Obstetrics.

Dr. Schulze graduated at the University of California in 1913 with the degree B. S., and in 1916 with the degree M. D. She served an internship in the Medical School in 1916, became an Assistant Resident in the Department of Obstetrics and Gynecology in 1917, and Resident in 1920 and 1921. Appointed Instructor by the University in 1921, she was promoted to Assistant Professor in 1931, serving competently and whole-heartedly in each of the many duties to which she was assigned.

While Resident, she became greatly interested in gynecological-obstetrical pathology, and gradually built up for the school a most satisfactory pathological museum, which served as the base for the excellent course in this specialized pathology which she conducted most ably for many years.

An unusually large proportion of gynecological admissions at the University of California Hospital are tumor cases, and these gave Dr. Schulze the opportunity of studying many atypical forms of neoplasms early in her career. Nearly twenty years ago she wrote the chapter on mammoth ovarian tumors in *Pelvic Neoplasms,* published by Appleton, which, to my mind, is as perfect a chapter on the subject as one could wish to see. For the first meeting of the Pacific Coast Gynecologic Society, in 1932, she presented a study of granulosa-cell tumors of the ovary, which is one of the first satisfactory papers on this subject in American literature.

All papers read by Dr. Schulze, for publication or not, were prepared most meticulously, whether for ward rounds, lectures, or for some medical society. They were written only after she had reviewed the entire literature of the subject, each item of which she herself read. When the paper was built on our own hospital records, she herself abstracted each individual case history and attempted to evaluate its worth. No wonder she was not a prolific writer. She learned, as Whitridge Williams taught, that proper preparation of one paper should consume the major part of one year. So papers written by Margaret Schulze will be sound reading for a long time to come.

While Resident Gynecologist, Dr. Schulze developed an excellent operative technique. She operated deftly and carefully. Her knowledge of pathology and her good common sense gave her unusually good surgical judgment in both gynecology and obstetrics. Students and Junior Staff Officers, who always recognize ability when they see it, brought their wives to her for advice and treatment almost in droves. Patient, gentle, and kindly, she cared for them no matter how it crowded her time. And as the years went by, she developed a clientele which loved her and was loyal to her every move.

No wonder, then, that when stricken in her 48th year, in comparative youth, she long since has been accorded national recognition as an able surgeon, a splendid teacher, an excellent author, and a sound pathologist.

Loyal, able, gentle almost to the point of shyness, she reflected from every angle the absolute intellectual honesty in which she lived and breathed.

Her passing creates a void in Pacific Coast Gynecology that will be most difficult to fill.

FRANK W. LYNCH.

✤

Ernest W. Fleming
1861—1943

Dr. Ernest W. Fleming died from carcinoma of the lungs, at his residence in Los Angeles, on Sunday, March 7, 1943, at the age of 82.

Dr. Fleming was graduated from the University of Michigan in 1885, had postgraduate general hospital training in New York City, ear, nose, and throat training later in Bellevue Hospital and the New York Polyclinic, thence to London and Germany. In Germany he worked under Schwartze, noted or his mastoid surgery.

Dr. Fleming settled in Los Angeles in 1892, confining his practice to the ear, nose and throat; the only specialist in Los Angeles who did so at that time.

Dr. Fleming was a founder member of the Los Angeles Ear, Nose and Throat Society and a member of the American Laryngological, Rhinological and Otological Society since 1899, also a member of the American Medical Association and the California Medical Association.

His brother specialists as well as the general practitioners had the greatest respect for Dr. Fleming's sincerity, courtesy and strong sense of professional ethics.

HILL HASTINGS, M.D.

✤

Montague Sydney Woolf
1883—1943

Few men have left a more lasting impression of gentleness, devotion, and friendliness amongst those who were closely associated with him than Dr. Montague Sydney Woolf, who passed away April 20th. He possessed the rare quality of making close friends and keeping them. He sought to help others and to do good, and his professional training assisted him in accomplishing his desire to alleviate suffering and to make the way happier for those with whom he came in contact.

Doctor Woolf was born in Plymouth, England, was educated in Birmingham, and with a scholarship in modern languages spent a year at Bonn and Heidelberg. But his true calling was medicine, which he studied at the University College Medical School of the University of London. He was granted a scholarship in Anatomy and Physiology, and received medals in Pathology and Clinical Surgery. In the World War he served in the Royal Army Medical Corps, as a civilian surgeon at army barracks in England, and in the British Naval Transport Service. As ship's surgeon he visited New York, where he left the Service at the close of the war, finally arriving in San Francisco.

In 1918, Doctor Terry appointed him Resident Surgeon at the University of California Hospital, with which institution he kept close association on the teaching staff and as visiting surgeon. In 1925, Doctor Woolf went to London, where he fitted himself to follow his specialty of proctology. His hospital connections besides the University Hospital were Children's, St. Mary's, and Southern Pacific. His publications in national and local journals were largely on subjects connected with his specialty, but his general training qualified him to write a text-book: "Principles of Surgery for Nurses," which was published in 1925.

While those of us who knew Monty best feel keenly his absence from our midst, we shall treasure memories of his fidelity and gentle manliness, and shall miss grieviously his "Cheerio."

RICHARD W. HARVEY, M.D.

THE WOMAN'S AUXILIARY TO THE CALIFORNIA MEDICAL ASSOCIATION†

MRS. F. G. LINDEMULDER.....President
MRS. RENE VAN DE CARR.....Chairman on Publicity
MRS. ROSSNER GRAHAM..Asst. Chairman on Publicity

A program dealing with "Wartime Medicine in the South Pacific" was heard by members of the Alameda County Medical Auxiliary when they gathered at the Rock Ridge Women's Club for their regular April meeting.

Lt. Robert Dennis Lee, Medical Corps, U. S. Navy, spoke on "The Practice of Medicine Under Combat Conditions." Dr. Lee has been on active duty with the fleet for the past year. Lt. Beth Veley of the Army Nurse Corps, one of the last persons to leave Bataan before its fall, gave an interesting account of the care of the sick and wounded and of their escape from Bataan.

The benefit parties given by individual Auxiliary members for the Philanthropic Fund have proved very successful. Among members who have entertained for this purpose are Mesdames T. Floyd Bell, Hobart Rogers, Roy Nelson, Albert Boles, Wallace Partch, C. J. Lundsford, T. C. Lawson, Charles DeVaul, S. M. Babbington, L. R. Jacobus, W. O. Solomen, Walter Rapapport, LeRoy Hahn, Grant Ellis, Harold Lambert, Kenneth Thompson, John Blum, E. Greer, and Henry Mankin.

The March meeting of the Marin County Woman's Medical Auxiliary was held at the Travelers Inn, in San Rafael. Mrs. R. B. Hartman presided.

The speaker for the evening was Mrs. Sigrid Clark, who discussed the functions of nurses' aides and told what a splendid work these women are doing in Marin County.

At a business meeting following dinner, it was decided to have members of the Auxiliary serve at the U.S.O. house for several days in April.

Because of the large area included in the Los Angeles County Auxiliary, Long Beach, Glendale, and Pasadena each conduct their own meetings. Once a year, however, each one is hostess to the entire group. Long Beach members were hostesses at the Pacific Coast Club in Long Beach.

Speaker of the day was Mr. Boyd Comstock, whose topic was "Italian Reaction to Nazi Domination." Mr. Comstock, formerly athletic coach at the University of Southern California and at Yale University, was recently with the Italian Government in their program for the Development of Young Italian Athletes. He returned to the United States last fall on the exchange ship, "Drottingholm."

Hostesses for the day included Mrs. Ralph Eusden, Mrs. G. Raphael Dunlevy, and Mrs. Horrace McCoy. Mrs. Franklin Farman, President, presided.

Dr. Henry Newman, Assistant Professor of Neuropsychiatry at Stanford University Hospital, gave an interesting talk on "Clinical Effects of Alcohol and Safe Driving," when the Woman's Auxiliary to the San Francisco Medical Society held their regular March meeting.

At the business meeting, the report of the Nominating Committee was read, and the Officers and Directors were elected. Plans were discussed for the Annual Benefit Bridge Party which is given each year for the Student Loan Fund. Mrs. Norman Morgan, Hospitality Chairman, arranged the tea, assisted by Mrs. William Reilly and Mrs. Frederick Fellows. Guests of honor were wives of doctors in the armed forces.

This year the Medical Auxiliary has been one of the many National and State organizations that has coöperated in the Cancer Control Educational Program of the Women's Field Army of the American Society for the Control of Cancer, Inc. Mrs. F. G. Lindemulder, the California State President of the Medical Auxiliary, has served as a member of the State Advisory Board to the Women's Field Army. Mrs. Kaho Daily was appointed as State Chairman to represent the Auxiliary.

Throughout the State the County Auxiliaries have helped in various ways. Some have made donations. Auxiliary members have served as officers or helped in the distribution of literature and helped in the street drives, and too, they are helping in the War Service Program.

The annual April membership campaign was preceded by a tea given in the home of Mrs. Clifford Andrews Wright, in honor of the State and County Executive and Advisory Board members, also the Advance Gifts Committee Chairman. Mrs. Wright is Honorary Commander of the Los Angeles County Division and serves as a member of the State Advisory Board.

Four hundred fifty high schools were contacted in the State, and suggestions were made that through the science, biology or health courses, accurate general information be obtained from representatives of the American Society for the Control of Cancer in their community, and that it be used in classroom discussion.

A five-hundred-word essay contest was sponsored among California high school students on the subject, "Fight Cancer With Knowledge." A twenty-five dollar war bond is to be offered for the best essay submitted.

Over one hundred junior colleges, colleges, and universities have been stimulated to obtain scientific material in the form of pamphlets, books and films.

As a part of the War Service Program, in response to requests from the Red Cross Chapters, a brief talk on the care of cancer patients was prepared for instructors, to be included in their lectures to the Volunteer Nurses Corps and the Home Nursing course. Small organized groups have been making surgical dressings to be distributed to unhospitalized cancer patients.

† Prior to the tenth of each month, reports of county chairmen on publicity should be sent to Mrs. Rene Van de Carr, 51 Prospect Road, Piedmont. For roster of state and county officers, see page 6, in front advertising section.

The April issue of two hundred and forty-six magazines throughout the country have again made a tremendous contribution by donating space for announcements, editorials and special articles.

In California the physicians have coöperated by serving as members of the State and County Executive Committees, lecturing, writing articles and giving radio talks; in general, guiding this Educational Program in order to keep it within the standards of scientific medicine.

The educational progress in cancer control is basically one of personal contact and personal participation. At the annual National Board meeting in New York, there was a general agreement as to the desirability to adhere to the previously established policy in the Cancer Control Educational Program to emphasize the hopeful side of Cancer.

CALIFORNIA PHYSICIANS' SERVICE†

Beneficiary Membership

Commercial (March, 1943)		42,600
Rural Health Program		5,000
War Housing Projects (approximate)		41,000
Marin	6,000	
Los Angeles	7,500	
San Diego	12,500	
Vallejo	15,000	
Total		88,600

The program of converting the full coverage membership to the New Two Visit Deductible and Surgical Plan is now 75 per cent complete. There has been no significant loss of membership as a result of the conversion, and in the main, beneficiary members recognize the necessity for the change and have accepted the situation without resentment. We find the surgical coverage for dependents has received wide acceptance.

During the past year, turnover in employment has been very rapid, and as a result our cancellation rate among members changing to new jobs has been very heavy. Nevertheless, we have been able to more than hold our own, even though the net increase has been small. Naturally, acquisition expense ratios in relation to continuous membership have increased. It has been difficult to find and retain competent administrative and office personnel, and higher wage rates are prevalent in all levels.

In spite of these difficulties, however, the new form of membership is returning a better compensation to professional members. Following is a review of unit values paid during recent months:

July, 1942	$1.30
August	1.30
September	1.40
October	1.40
November	1.40
December	1.50
January, 1943	1.60
February	1.75

† Address: California Physicians' Service, 153 Kearny Street, San Francisco. Telephone EXbrook 0161. A. E. Larsen, M. D., Secretary.

Copy for the California Physicians' Service department in the OFFICIAL JOURNAL is submitted by that organization.

For roster of nonprofit hospitalization associates in California, see in front advertising section on page 3, bottom left-hand column.

CALIFORNIA PHYSICIANS' SERVICE
A Nonprofit Corporation
153 Kearny Street, San Francisco
IMPORTANT MEMORANDUM

To: Physicians and Nurses—

Certainly we all know that California Physicians' Service has found the going difficult during the past four years. We believe that most of the faults have now been corrected and that you will be interested in a brief report of C.P.S. activities, because they affect you and the rest of the medical profession throughout the State.

1. C.P.S. started operations in 1939 with a full coverage contract. We have found that this type of contract was difficult to administer, and that under it the plan has been subjected to excessive use of service by a minority of beneficiary members, with the end result that the doctors received very little for their services. In the summer of 1942, we developed a much simpler 2-visit deductible plan, and have already converted approximately 80 per cent of the full coverage contracts to the new plan. The contracts of the remaining members will be converted within the next two or three months.

This new plan has corrected many of the defects of the old plan, and has eliminated most of the complaints and problems of doctors and beneficiary members. Since the start of this conversion program in September of 1942, the unit value has increased 36 per cent, and we confidently expect further betterment. The conversion to date has been accomplished without any significant loss of membership.

In the new 2-visit deductible plan, you are to charge the member your usual fee for the first two visits, just as if he were a private patient. If x-ray, laboratory tests or surgical operations are necessary during the first or second visit, their cost will be paid from the C.P.S. fund. Continued treatments beyond two visits and beginning with the third visit will be payable from the C.P.S. fund.

Our enrollment efforts are concentrated upon this 2-visit deductible plan, and upon the surgical plan, and we are pointing our efforts directly to the "lower income groups"—that is, where family incomes do not exceed $3,000.00 per year.

2. Since 1941, many thousands of new families have moved into California from all parts of the United States to find employment in the enormous war industries that have been built up here. In order to provide housing for these families, the federal government has built temporary housing adjacent to these war industries. However well this action has solved the problem of housing, it has created new problems, most important of which is the lack of adequate medical care. This difficulty was further aggravated by the withdrawal of doctors from these communities to fill the needs of the armed services. Other districts of the State could not spare sufficient individual physicians to relocate themselves for practice in or near these housing projects.

There seem to be several alternative methods of solving this problem:

a. The United States Public Health Service could secure physicians (in effect, through the draft), put them in uniform and on salary—straight government medicine.

b. Employers in the industries in which these people were employed could set up their own plans, as Mr. Kaiser did, with physicians on salary.

c. Profit-making health service organizations could contract to furnish care—with physicians on salary.

d. Or the medical profession itself, through its own service organization (C.P.S.) could undertake the job, employing physicians to furnish services necessary on the

projects, and referring patients who required more extensive work or hospitalization to the C.P.S. professional members of the local communities, whom the patient may select.

Faced with this practical and very urgent and pressing situation, the Board of Trustees of C.P.S. felt that it was better for the medical profession to undertake the job itself, thereby controlling standards of service and preserving as much as possible of free choice and the valued patient-physician relationship. Before C.P.S. had entered into agreements on any of these projects, the local County Medical Society and the physicians of the community were consulted and their approval obtained—and not only their approval, but their coöperation in the administration of the service. Income from these projects has been kept separate from regular C.P.S. funds, and so far the operation has returned a unit value ranging between $1.75 and $2.50 to the local professional members.

In these undertakings we have had the utmost of cooperation from the Federal Public Housing Authorities, from the United States Public Health Service, the Procurement and Assignment Service and from the Council of the California Medical Association. Unofficially, Federal officials say that California is the only State in the Union in which the organized medical profession has set up a better solution for the health problems of these congested areas than the Government itself had hoped to supply. A directive has been issued by the War Department that all officers and civilian heads of departments should contact health service plans in their communities and give every assistance to the enrollment of civilian employees of the War Department, so that they may budget the cost of their illnesses through these channels.

3. Today C.P.S. has approximately 5,200 professional members. We will do our best to keep you and your office staff informed as to the activities and developments of this doctor-owned organization. There are several compulsory health bills up before the State Legislature at this session, which if passed would have a definite effect upon the practice of medicine in California. The numbers of these bills are S.B. 885 and A.B. 1079. Your continued support of C.P.S. is the best instrument with which to combat such compulsory legislation.

If there should be any questions regarding our activities or procedures, please call or write our office. We appreciate your coöperation, and we assure you of ours at all times.

Sincerely yours,
California Physicians' Service.

* * *

California Physicians' Service
153 Kearny Street
San Francisco, California

Dear Doctor:

We intend to give you, each month, a brief report of the activities and operations of California Physicians' Service. In last month's statement to you, a folder describing the benefits to employed groups was enclosed. Many doctors have written for an additional supply so that they can be given to their "lower income patients." California Physicians' Service is developing its membership in groups whose family income is less than $3,000.00 annually. We will appreciate any help you can give us in securing more of these groups. . . .

Again in January the "unit" for medical service increased in value. Our two-visit deductible medical and the surgical contracts are partly responsible for this increase.

Financial operations for the month of January were as follows:

Dues collected	$45,169.80
Late dues and unused portion of prior allocations	2,564.32
Professional Member dues	75.00
	47,809.12
Cost of Administration	11,306.60
Available for January business	36,502.52
X-ray and lab. on hospitalized patients	3,172.50
Available for remaining professional services	33,330.02
20,095.1 units of service, at $1.60	32,152.60
Transferred to Unit Stabilization Fund	1,177.42
Previous balance in Fund	29,538.67
Total Unit Stabilization Fund	$30,716.09

A. E. Larsen, M. D.
Executive Medical Director.

March 22, 1943.

* * *

Medical Center to Be Pattern For Projects

The Harbor Gate project in Richmond will be the first of California's housing projects to create medical services patterned on Marin City's medical center, stated William Reidy, State medical services coördinator for the FPHA.

Marin City's prepaid medical plan is operated by the California Physicians' Service, and assures complete care for all members of the family.

Focal point of the plan here is the Medical Center. It is staffed by the adult doctor, Dr. Julius Alsburg; pediatrician, Dr. Myrl Morris and three office nurses and one home visiting nurse.

When the new Center building is completed, it will include space for a 12-bed women's and children infirmary.

Health defenses at Marin City also include the Well-Baby Clinic, held bi-monthly at the Community Building. This service was initiated by the Marin County Health Department under the direction of Dr. Irving Johnson.

"Sixty thousand out of 150,000 doctors in the United States are being taken into the armed forces," said Reidy. "Marin City residents are fortunate that their medical care assures them of the services of two doctors, who cannot be taken away before replacements are made."
—Sausalito *News*, March 11.

California Physicians' Service: Two Letters

In a recent issue of the Bulletin of the *Los Angeles County Medical Association* appeared two letters by Doctors Madeline J. Algee and Alson R. Kilgore, dealing with activities of the California Physicians' Service.

(Letter of Doctor Algee)

January 4, 1943.

Editor, The Open Page of the Bulletin of the Los Angeles County Medical Association:

The predictions of the ignored majority of the State Medical Association have come to pass. The California Physicians' Service plan was urged upon us by a minority faction with the promise that it would prevent exactly the situation stated in *Medical Economics*, December, 1942, to have been established by California Physicians' Service with the approval of the State Medical Association in Marin City. Fees for medical care are being collected with the rent and physicians employed on salaries ranging from $300 to $600 a month are being hired by California Physicians' Service to care for the 40,000 workers and their families.

Is it no longer illegal for corporations to practice medicine?

The California Physicians' Service has advertised widely that it is sponsored by the California State Medical Association, but it is in no way controlled by it and differs in no way whatever from any other corporation which employs physicians on salaries and collects fees for their services from patients. Is this not what the State Medical Association has aimed to prevent? Have we been betrayed?

Please, State Medical Association, explain this away.

MADELINE J. ALGEE, M. D.
508 N. Long Beach Boulevard, Compton, Calif.

* * *

(Reply Letter of Doctor Kilgore)

March 15, 1943.

Editor, The Open Page of the Bulletin of the Los Angeles County Medical Association:

The letter from Dr. Madeline Algee on your "Open Page" of January 21st may already have been answered. But if not, may I do it? Because at least the main question raised is an entirely proper one and deserves an answer.

She states that California Physicians' Service is in no way different from any other corporation employing physicians on salaries and asks if by so employing physicians to serve in health centers on war-industry housing projects the rest of the doctors in California have not been "betrayed." Is this not, she asks, exactly the situation that a "minority faction" promised the "ignored majority" C.P.S. would prevent?

In the first place, C.P.S. is not, by any stretch of imagination, the same as any other corporation. It is 5,500 physicians of California organized to provide service to its beneficiary members under the changing conditions of medical practice. Its services and its methods of operation are directly under the control of those physicians through their elected administrative members and the Board of Trustees.

In the second place, probably none of us on either side of the C.P.S. debate of 1938 foresaw "exactly the situation" of thousands of war workers and their families, concentrated in new housing projects with no medical care on the projects and quite inadequate medical care in nearby towns (3,600 people live at Marinship today and this number is rapidly increasing. Sausalito, the only adjacent town, has three physicians, already busy in the town itself.)

If one will ask himself what he would do as a member of a housing authority, responsible for reasonable facilities in these new communities, the answer is, he would see to it that, in some way or other, medical care is made available.

Waiting for individual physicians to establish themselves for practice in or near these housing projects is impossible. So far, to my knowledge, no physician has even offered to try it.

There are alternative methods. The U. S. Public Health Service could secure physicians (in effect through the draft), put them in uniform and on salaries—straight government medicine. Employers can set up their own plans, as Mr. Kaiser did, with physicians on salaries. Profit-making health service organizations could contract to furnish care—with physicians on salaries. Or the medical profession, through its own service organization, C.P.S., can undertake the job, employing physicians to furnish service necessary on the projects and referring patients who require more extensive work or hospitalization to any C.P.S. Professional Members whom the patient may select. But there is no alternative to the employment of physicians by someone or some organization.

Faced with this practical and very urgent and pressing situation, is it better that the government or a private contractor take these people entirely away from the medical profession as patients or that the medical profession undertake the job itself, controlling standards of service and preserving as much as possible of "free choice" and the valued patient-physician relationship?

Finally, before any of these projects has been entered upon, the local County Medical Society and the physicians of the community were consulted and their approval obtained and not only their approval but their coöperation in the administration of the service.

These being facts, words like "minority faction," "ignored majority" and "betrayed" seem fairly uninformed to those who know the problems and the dangers to medicine inherent in their non-medical solution.

Very sincerely yours,

ALSON R. KILGORE, M. D.
San Francisco, Calif.

MEDICAL EPONYM

Milroy's Disease

William Forsyth Milroy (b. 1855), professor of clinical medicine and hygiene in the Omaha (Nebraska) Medical College, read a paper entitled "An Undescribed Variety of Hereditary Oedema" before the Society of the Alumni of Charity Hospital on June 1, 1892; this was published in the *New York Medical Journal* (56:505-508, 1892). He described the condition as follows:

"On August 20, 1891, Mr. H. presented himself for examination for life insurance. . . . The applicant called my attention to his lower extremities. I found a condition of oedema involving the feet and extending up the legs to the knees. . . . Upon inspection, the leg presented a slightly rosy hue. . . . Scattered thickly over this base were white spots about the size of a pea. . . . Mr. H. stated that this oedematous enlargement had existed from birth. . . . that this enlargement of the extremities was a family characteristic which he had inherited from his mother. Fortunately for the purpose of this study . . . in 1883 a member of the family published a neat volume, giving the family history in America for a period of two hundred and fifty years. . . . The peculiarity now under discussion seems to have entered the family by marriage about 1768. With the aid of this volume and the assistance of members of the family still living, I am able to offer the facts which I present. . . .

"1. So far as known, in every case, with two exceptions only, the oedema was present at birth.

"2. The location of the oedema has in every case been limited to one or both lower extremities.

"3. The presence of the oedema is persistent, never having been known to disappear, temporarily or permanently, except in one instance.

"4. It has never been attended by constitutional symptoms, barring the two possible cases in which its first appearance was subsequent to birth.

"From these considerations it seems evident that the case under discussion is not one of angeio-neurotic oedema. . . . Whether or not the case is one of nervous edema, it is offered that, with others, sufficient material may be accumulated to render possible study of these unusual forms of oedema.—R. W. B., in *New England Journal of Medicine.*

MISCELLANY

Under this department are ordinarily grouped: News Items; Letters; Special Articles; Twenty-Five Years Ago column; California Board of Medical Examiners; and other columns as occasion may warrant. Items for News column must be furnished by the fifteenth of the preceding month. For Book Reviews, see index on the front cover, under Miscellany.

NEWS

Coming Meetings†

California Medical Association. Place and date of the 73rd Annual Session, to be held in 1944, to be announced later.

* * *

American Medical Association. No meetings of Scientific Assembly. Meeting of House of Delegates will be held in Chicago, on Monday, June 7, 1943.

The Platform of the American Medical Association

The American Medical Association advocates:

1. *The establishment of an agency of Federal Government under which shall be coördinated and administered all medical and health functions of the Federal Government, exclusive of those of the Army and Navy.*

2. *The allotment of such funds as the Congress may make available to any state in actual need for the prevention of disease, the promotion of health, and the care of the sick on proof of such need.*

3. *The principle that the care of the public health and the provision of medical service to the sick is primarily a local responsibility.*

4. *The development of a mechanism for meeting the needs of expansion of preventive medical services with local determination of needs and local control of administration.*

5. *The extension of medical care for the indigent and the medically indigent with local determination of needs and local control of administration.*

6. *In the extension of medical services to all the people, the utmost utilization of qualified medical and hospital facilities already established.*

7. *The continued development of the private practice of medicine, subject to such changes as may be necessary to maintain the quality of medical services and to increase their availability.*

8. *Expansion of public health and medical services consistent with the American system of democracy.*

Medical Broadcasts*

The Los Angeles County Medical Association:

The following is the Los Angeles County Medical Association's radio broadcast schedule for the current month, all broadcasts being given on Saturdays.

During the month of May, the broadcasts will be given on the following Saturdays: May 1, 8, 15, 22 and 29.

KFAC presents the Saturday programs at 8:45 a. m., until the title, "Your Doctor and You."

The Saturday broadcasts of KECA are given at 10:30 a. m., under the title, "The Road of Health."

"Doctors at War":

Radio broadcasts of Doctors at War by the American Medical Association in coöperation with the National Broadcasting Company and the Medical Department of the United States Army and the United States Navy are on the air each Saturday at 2 p. m. Pacific War Time.

† In the front advertising section of *The Journal of the American Medical Association*, various rosters of national officers and organizations appear each week, each list being printed about every fourth week.

* County societies giving medical broadcasts are requested to send information as soon as arranged.

Pharmacological Items of Potential Interest to Clinicians*:

1. *Books Roll On:* Oleanders (Galveston orchids), to A. W. Ham and M. D. Salter of Toronto for their skillful *Doctor in the Making: The Art of Being a Medical Student* (Phila., Lippincott, 1943). Ditto to Y. Henderson and H. Haggard for a concise 2nd edition of their standard *Noxious Gases* (Reinhold, N. Y., 1943). Ohio State University Development Fund, Columbus, announces English edition of Paul Bert's classic *Barometric Pressure*, by M. A. and F. A. Hitchcock, at $9.00 prepublication. W. S. Cutting offers a *Manual of Clinical Therapeutics* (Phila., Saunders, 1943). R. D. Herrold briefs the *Chemotherapy of Gonococcic Infections* (St. Louis, Mosby, 1943). I. Galdston gives a popular peek *Behind the Sulfa Drugs: A Brief History of Chemotherapy* (N. Y., Appleton, 1943), which isn't as informative as M. Silverman's chapters in his *Magic in a Bottle* (N. Y., MacMillan, 1941). C. C. Thomas of Springfield, Ill., offers A. Coca's *Familial Nonreaginic Food-Allergy*, and the *Medical Progress Annuals.* P. Wylie's *Generation of Vipers* (N. Y., 1942), makes me wonder. W. Saroyan's *Human Comedy* (N. Y., 1943), makes me wishful. J. Fortune and J. Burton's *Elisabet Ney* (Knopf, N. Y., 1943), illustrates many of the points of K. Menninger's *Love Against Hate* (N. Y., 1943), and gives the lowdown on old Texas.

2. *Nature:* (the magazine), like Univ. of California, celebrates its 75th birthday, and properly notes centenary of MacMillan, its publisher. In recent issues: P. C. Koller shows increased rate of cell division due to quantitative change in nucleic acid synthesis (151:244, February 27, 1943); B. Macgraith, G. M. Findlay and N. Martin (in West African Force), find evidence for red cell lytic enzyme usually held in check by inhibitors in tissues and plasma (*ibid.*, p. 252). P. B. Medewar, et al., find 8-hexenolactone inhibits fibroblastic growth but not epithelial (*ibid.*, p. 195). J. Barcroft, et al., come back brilliantly by finally showing that sodium acetate is used by mammalian heart and at about same rate as glucose (*ibid.*, p. 304, March 13, 1943).

3. *Medicine:* (the magazine), comes across with 3 good reviews in February issue (Vol. 22, No. 1): D. McEachern on thymus in relation to myesthenia gravis; R. Ottenberg and R. Spiegel on nonobstructive jaundice due to chemicals, and G. Martin and M. R. Thompson on intravenous alimentation with amino-acids.

4. *Public Health:* The scientific question about vitamins contributing to physical fitness is finally answered affirmatively by A. A. Harper, et al. (*Brit. Med. J.*, 1:243, February 27, 1943). C. A. Mills shows positive correlation between urban air pollution and incidence of respiratory diseases (*Amer. J. Hyg.*, 37:131, 1943). Say, maybe we have to do more fighting on the home front in this war: Don't we need lots of people with brains and ability to help reduce the alarming increase in preventable diseases like tuberculosis, pellagra, diphtheria, spotted fever, mental disorder, and especially venereal disease?

* These items submitted by Chauncey D. Leake, formerly Director of U. C. Pharmacologic Laboratory, now Dean of University of Texas Medical School.

5. *Otherwise:* From Lima, Peru, comes the new *Revista de Medicina Experimental,* with C. Gutierrez-Noriega's report on the medullary vasoconstrictor center. O. H. Robertson (*Science,* 97:142, 1943), says triethylene glycol is the best of all glycols for sterilizing air (1 mgm per 200 liters of air—0.1 c.c. per 800 cu. ft.). J. J. Lalich and A. L. Copley (*Arch. Surg.,* 46:224, 1943), note that dicoumarin doesn't much decrease clot resistance in wound thrombi. Australian Committee on Survey of War Medicine has excellent review on treatment of burns (*Suppl. 7, Med. J. Austral.,* January, 1943). H. O. Calvary and crew begin work on bacterial pyrogens (*J. Amer. Pharm. Asso.,* 32:65, 1943). D. Court and S. Taylor find pitressin tannate suspended in peanut oil effective on single intramuscular injection in controlling diabetes insipidus for many days (*Lancet,* 1:265, February 27, 1943). C. H. Rammelskamp and C. S. Keefer find penicillin absorbed and excreted more rapidly after intrathecal injection in meningitis patients than in healthy humans, and wish less untoward effect (*Amer. J. Med. Sci.,* 205:342, 1943). Vale to Edgar Allen using colchicim to produce cellular mitosis to study differential growth in ovaries of rats (*Amer. J. Anat.,* 72:291, 1943).

Napa County Medical Society Meeting at Napa State Hospital, Imola.—On Wednesday evening, April 7th, members of the Napa County Medical Society and military colleagues from Mare Island and Hamilton Field were guests of the medical staff of the Napa State Hospital at Imola.

Dr. Karl M. Bowman, Director of the Langley Porter Clinic of the University of California Medical Center in San Francisco, spoke on "The Relationship of the Langley Porter Clinic to the General Practitioner." Dr. Joseph H. Catton gave an illuminating address on the subject, "Nerves and the Military." The discussion by members and physicians who are in active service with the Armed Forces was most interesting. A total of 68 physicians were present at the meeting.

Assemblyman Ernest Crowley made a brief speech, in which he emphasized the point that it is most desirable for members of the medical profession to contact the Legislators from their respective constituencies on prospective legislation pertaining to the public health and maintenance of medical standards so that members of the State Senate and the State Assembly will be in position to have a proper understanding of issues presented to them. C.M.A. officers who were present included President-Elect Karl L. Schaupp; Past-President Henry S. Rogers; Councilor John W. Green; Chairman of the Committee on Public Policy and Legislation, Dwight Murray; and Secretary-Editor, George H. Kress.

Vallejo Community Hospital.—City officials, architects, sponsors, contractors and others interested in the Vallejo Community Hospital, participated in the official ground breaking for the structure Monday, (4/5) and annnouncement was made that the structure would be completed, ready for use, in 180 days.

This 262-bed institution is being constructed by the Emergency Operations Unit of the Public Buildings Administration of the Federal Works Agency, and will provide adequate hospital facilities and service for the 100,000 people now resident in Vallejo. It is located to the right of the Napa Road, one mile north of Vallejo. It will have an emergency capacity for 300 to 350 beds.

Barrett and Hilp, general contractors, San Francisco, are the contractors for the $1,100,000 project, and Douglas Dacre Stone, San Francisco, is the architect. . . .

J. Hayden Perkins, commissioner of public health and safety, of Vallejo, led the campaign for the new hospital and was the chief sponsor for the new federal project.

In addition to the main group of connected buildings, containing 12 wards and 150,000 square feet of floor space, there will be two homes for the 100 nurses and two buildings to house the 40 other resident employes. . . .

Surrounding the buildings on the 20-acre plot, will be wide areas of lawn to prevent any dust blowing into the hospital. Roadways are beyond these grassed spaces except for the emergency entrance. These features are all standards of the U. S. Public Health Service.

Stone explains another construction method which helps reduce the per-bed cost of the completed hospital to approximately $5,000, a remarkably low figure. It is the use of the module system of measurement. One module is equivalent to four feet and all dimensions are given in modules. This unit of measurement fits almost every kind of material used with a minimum of waste and also speeds up the actual construction work.

"From the out-patient department to the x-ray rooms, the laboratories, pharmacy, dental department and all the wards, the hospital will be absolutely modern and up to the standard required by the U. S. Public Health Service," says Stone. "Every item of equipment is provided for, $200,000 of the contract price covering these facilities. When completed this national investment in the public's health will give Vallejo the best hospital that modern science knows how to build."

New Veneral Disease Isolation Unit in Los Angeles.—The Venereal Disease Control Divisions of the City and County Health Departments have for some time been active in promoting an isolation unit for genitoinfectious diseases at Los Angeles County General Hospital. Through Lanham Act funds it is expected the hospital will be enabled to set up this isolation unit. The ward, designated 10,800, is to open, subject to final approval of Washington, to receive females either strongly suspected of having, or known to be infected with syphilis or gonorrhea. The ward is a 40-bed unit and will be staffed and supplied by the hospital. Members of the City and County Health Departments are to be made members of the attending staff under the direction of Dr. Kendal Frost, Director of the Department of Dermatology. The expensive communicable disease technique, as formerly applied to in-patients with venereal diseases in the C. D. unit, will be modified to fit our present knowledge of the communicability of syphilis and gonorrhea. It is estimated that the modifications in technique will reduce the cost per patient day from $15 to $4.

The patients are to be held in the ward under quarantine until their infection of gonorrhea is cured or, in the case of syphilis, until such time as they are rendered noninfectious. The approximate maximum period of quarantine will be three months. Persons referred to this unit are to be mainly the reported contacts of infection in military personnel; however, civilian contacts who prove unresponsive to the usual follow-up procedures will be isolated as well. Also, clinic patients who have infectious gonorrhea or syphilis and who prove to be recalcitrant or who persist in acts which tend to spread their disease, will be quarantined. It is hoped that many of the persons will voluntarily accept quarantine in order to take advantage of hospitalization. There is absolutely no intention of making this ward a jail or punishment for having a venereal disease. Patients will enjoy such benefits of hospitalization as are compatible with their infection and will be prosecuted under law only if quarantine is broken. The rules and regulations of this quarantine are as established by law.

Accepted methods of treatment for venereal disease are to be used. It is also planned to offer patients infected with early syphilis the rapid scheme of therapy as proposed and documented by Dr. Harry Eagle of the U. S. Public Health Service. This treatment requires 8 to 10 weeks for completion and the usual 5 to 10 years of post-treatment observation. This isolation unit is a forward step in the control of syphilis and gonorrhea.

Nylon Suture Material.—Millions of feet of nylon monofilament that formerly went into tennis racquet strings and fishing leaders may replace silk this year in surgical sutures for the Army, Navy, civilians, and lend-lease shipments.

Surgeons use as small a suture as is consistent with the strength required, for the smaller the material the less the chance of irritation. Nylon has greater tensile strength than silk and can be produced in uniform diameters.

The synthetic is so inert and nonirritating that it can be used internally as well as externally. It does not fray or splinter. There is no chance of small slivers wearing off the suture and working through the body.

Examinations for Interns.—The Los Angeles County Civil Service Commission announces that applications for the position of Intern in the Los Angeles County Hospital will be accepted from Wednesday, February 17th, until Thursday, April 15th. There will be no written test. Candidates will be rated on their professional training and experience, and their aptitude and personal suitability for internship, as evidenced by investigation or interview.

All candidates must be citizens of the United States who have completed a medical course at an approved medical school in the United States or Canada, within five years prior to April 15, 1943, or who will have completed the course prior to July 1, 1944.

Application blanks may be secured from Deans of any of the accredited medical schools or full information may be obtained by writing directly to the Los Angeles County Civil Service Commission, Room 102, Hall of Records, Los Angeles, California.

International College of Surgeons to Meet in June.—The Fourth International Assembly of the International College of Surgeons will be held on June 14, 15 and 16, at the Waldorf Astoria Hotel, in New York City. Delegations made up of surgeons from the United Nations in addition to those from other countries are expected to attend.

American Board of Opthalmology.—Examinations will be held in New York City, June 4th and 5th, and in Chicago, October 8th and 9th. Candidates will be required to appear for examination on two successive days. For formal application blanks, write to Dr. John Green, Secretary, 6830 Waterman Avenue, St. Louis, Mo.

American Urological Association.—The $500 Research Prize annually offered by the American Urological Association will not be awarded this year. Under existing circumstances, plans for the June meeting of the American Urological Association in St. Louis have been cancelled.

Handbook of Diagnostic Instruments and Technique in Medicine.—A 72-page publication, illustrated, has been announced of a Handbook on the Reichert Collection, illustrative of the evolution and development of diagnostic instruments and techniques in medicine. The Collection itself is now on view as a loan exhibit at the Wellcome Exhibition Galleries (Burroughs Wellcome & Co.), in New York.

The Collection has been assembled by Philip Reichert, M. D., New York, for use as a reference laboratory by investigators interested in the field of methods and apparatus. It provides a careful map of the route along which our diagnostic armamentarium has come, and gives not only perspective for the present, but perhaps a clue as to the direction in which further development will be made.

The Handbook is designed primarily as a guide to the study of the objects in the Collection. The distribution of the Handbook is complimentary but will be limited to members of the medical and allied professions.

American College of Chest Physicians Cancels 1943 Meeting.—The following resolution was adopted by the Board of Regents of the American College of Chest Physicians:

Resolved, That the Board of Regents of the American College of Chest Physicians meeting in Executive Session in the City of Chicago, on the fourteenth day of February, in the year nineteen hundred and forty-three, hereby proposes that the 1943 annual session of the American College of Chest Physicians be cancelled.

It was recommended by the Board of Regents that wherever feasible, State and District Chapters of the College arrange to meet jointly with their State and District Medical Societies, and assist in preparing scientific programs concerning the specialty of diseases of the chest.

Civilian Defense: "War Emergency Radio Service."—The "War Emergency Radio Service, WERS," is a new system of two-way radio communication for use of Civilian Defense and other defense forces in local areas. It is rugged, home-grown, highly adaptable, and of the greatest use before, during, and after an air raid or other emergency.

WERS can be set up only by specific authorization of the Federal Communications Commission.

The FCC has assigned to WERS a number of frequencies, the more important being from 112 to 116 megacycles. Within this range OCD recommends that operation be planned for three bands of several channels each. At need there would be available 14 distinct channels so that there is no practical limit to the system's flexibility. . . .

The new emergency radio system is of direct use to many strategic centers and installations in the community, such as hospitals, industrial plants, railroad yards, docks, bridges, and public utilities. Its importance to these points appears in the two following representative cases.

1. *Industrial plants*— . . . .

2. *Hospitals.*—It is crucial to know during a raid exactly what beds are available and what operating rooms are free in the casualty receiving hospitals of a community, and to direct casualties rapidly to available facilities. If telephones go out, the control center can still keep a complete picture of the hospital situation by WERS. By use of the new system, ambulances can be loaded and disptached effectively because the control center is in communication both with hospitals and with the incident officers and incident medical officers. Mobile medical teams can be directed from point to point without returning to their bases. If the hospital facilities of an area become overtaxed, the radio channel to the district headquarters can arrange for reinforcing hospital facilities. For hospitals, WERS represents a communica-

tion asset whose value is written in terms of saved lives.

Thousands of volunteers are helping set up the new WERS system. Amateurs otherwise banned from the air are today helping to build and operate thousands of two-way stations needed throughout the country. In community and nationwide drives, attics and back rooms of radio repair shops are ransacked for junked sets and unused material—it is the existence of this material which puts the United States out in front as the country most ready for the rapid setting up of this fool-proof communications auxiliary. With the materials gathered, volunteer groups construct stations which become the property of the defense forces. Not only amateurs, but qualified repairmen, electrical trade unionists, and persons holding commercial radio operators' licenses, including radio engineers employed in broadcast stations, are joining in this work.

All the defense personnel who will operate the newly constructed stations must be trained, and each one specifically who will operate a station must obtain a permit from the FCC. This permit is not hard to get—after training, it means the passing of an elementary FCC test. Many Defense Councils have organized classes in WERS operation.

For further information on this subject, communicate with the Editorial Section, Office of Civilian Defense, Washington, D. C.

Dr. George Dock, Medical Dean, Still Student at 82.—Medical students used to relate a story about their favorite professor, Dr. George Dock.

"Ask any other teacher what time it was," they would say, "and he would pull out his watch and tell you.

"Ask Dock and he would pause, reflect a moment and finally mutter, 'That's an interesting subject. Let's look into it.'"

Dr. Dock's passion for inquiry and research has followed him through all the years.

Still a Student

Today, at 82, as dean of the medical profession in the Los Angeles area, he is still a student, engaged in studies designed to broaden medical knowledge.

A former associate of the great Osler, Dr. Dock, a practicing physician for 59 years, has made many contributions to his field.

He is proudest of his former students who have risen to eminence, seeing in their accomplishments an extension of his own aim—greater knowledge through research.

Author of Textbooks

His book, "Outlines for Case-Taking," is a standard text at most of the nation's medical schools. One of the first books published on hookworm disease came from his pen. He also edited a volume on the heart.

The years have not dulled the edges of the physician's mental processes. Associates say his mind is as keen as a scalpel. He has deep-socketed, appraising eyes that seem, at a glance, to make a complete diagnosis.

When he makes the usual amenity of asking, "How are you?" to a friend you feel he knows the exact answer even before the question is put.

Birthday Observed

Dr. Dock is the only physician whose birthday, April 1, is observed by the Los Angeles County Medical Association. A lectureship, sponsored by the Barlow Society for the Study of the History of Medicine, also is named after him.

In addition to his discoveries, Dr. Dock has made other contributions better known to the public at large. He is responsible for hospital beds being at their present height, a change he initiated more than 30 years ago when he observed how cots at a lower level tired attendants caring for patients.

He also instituted the first general use of white coats among hospital attendants, making use, at the start back in the '90's, of butchers' outfits.

Dr. Dock, who has offices in Pasadena, believes medicine is still in its infancy as far as research is concerned, pointing out that more knowledge has been gained in the last 50 years than in all the time before.

"The future," he says, "is an endless vista."—Los Angeles *Times*, February 21.

International College of Surgeons.—The coming fourth International Assembly of the International College of Surgeons will be held at the Waldorf Astoria Hotel in New York City, on June 14, 15, 16, dealing with the subjects of "Rehabilitation" and "War Surgery."

Visitors to the Assembly are urged to view the many exhibits which will be set up to demonstrate activities in military medical affairs and rehabilitation. . . . The Veterans Administration, Washington, D. C., of which Charles M. Griffith is Medical Director, will furnish charts showing pictures and descriptions of the routine and special measures in occupational therapy, and physical therapy used to aid in the treatment of patients in Veterans Administration Hospitals.

Autopsy Surgeon Examination.—A salary of $4800 a year is being offered by the Los Angeles County Civil Service Commission, to the doctor who is selected for the position of Autopsy Surgeon, M. D., for work in the Los Angeles County Department of Coroner.

There will be no written examination for this position as candidates will be rated on their professional training and experience and their ability and personal suitability for the work, as evidenced by investigation or interview.

Doctors, in age 21 to 55, with an M. D. degree from an approved medical school, who have completed at least one year's internship in an approved hospital and who have had two years of professional experience in the pathology laboratory of an accredited hospital, medical school, or commercial laboratory or in a public agency, may file an application for the permanent Civil Service position. Those over 55 years of age may file for "duration" work.

Full information may be obtained from the office of the Commission, Room 102, Hall of Records, in Los Angeles, California. Applications must be filed on or before Monday, May 24, 1943.

Doctors of Medicine as Others See Them.—During recent years, the medical profession and its work have been much misrepresented in certain lay publications. A perusal of editorial comments appearing in some California newspapers, in which appreciation is expressed for the healing and altruistic work of physicians, should therefore be of interest.

The above item, with some quotations appeared in CALIFORNIA AND WESTERN MEDICINE (July issue, pages 108-109; October, pp. 269-270; November, pp. 287 and 331-332; January, pp. 49 and 50; February, pp. 92-93, and April, pp. 225-257. More recent excerpts follow:

FREE CHOICE MEANS PROGRESS

A basic principle of democracy is free choice.

Significantly, extremists who urge adoption of broad compulsory health programs give scant attention to the basic principle.

Free choice guides every act in our daily lives. We can go to the church we choose, we can buy groceries from whom we please, we can choose the car in which we ride, we can say what we choose, we can choose the schools we wish to attend.

Whenever we abandon the principle of free choice, we hurt no one but ourselves. And that goes for medical service. Free choice of a doctor automatically encourages medical competence. The most qualified are the most patronized. As a result, every doctor is spurred on to achieve the reputation of being a good doctor.

This incentive, or whatever you wish to call it, is the background of every doctor's training. It embodies more than mere financial success.

Pride of accomplishment, the heart-warming feeling that people come to him because they believe in him, these are part of the incentive inspired by free choice which governs the career of the average doctor.

The same inspiration has been responsible for the miraculous scientific discoveries that have come from research laboratories of American medicine.

If we abandon the principle of free choice in the field of medicine, medical service will decline.—Isleton *Delta News*, March 5.

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They See Alike

The medical profession is not opposed to health programs that do not embody ultimate elimination of private medical practice. The doctors are no different than representatives of industry, agriculture or labor, who oppose plans that would place government in control of the economic affairs of the individual. They are alike in their conviction that a people cannot lean on a government too heavily and still retain freedom.

For example, government-subsidized coöperatives can give the consumer goods "at cost." Temporarily the consumer appears to benefit. Actually, he loses, because his neighbor is inevitably forced out of business—the stimulant of competition disappears, quality drops, and economic independence gives way to utter dependence on a monopolistic provider, government.

And so it is with medical service. The doctors know that present high standards cannot be maintained except under a system of private medicine. They gladly contribute much free time so that no one need suffer for lack of proper medical attention. During the war emergency, they are working night and day to preserve the nation's health. But they oppose health plans that would make the government the prime dispenser of medical care.—San Juan Capistrano *Coastline Dispatch*, April 2.

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From the Cradle to the Grave

President Roosevelt's "blueprint for peace," is too all-inclusive, too complicated, too far reaching for anybody but the seventh son of a Philadelphia lawyer to understand right offhand.

However, it does create the impression that the administration desires to remake the United States into a sweet land of never-worry, a Utopia where good old Uncle Sam will make all your decisions, guide your life, provide for your care when ill and support you when you quit your job or get old.

Silence of the new deal dreamers in the recent past probably can be explained now. They have been working out this super-new deal which would give the government increased power over the individual from the cradle to the grave.

It's a pretty picture—full employment for all employables, jobs guaranteed for the soldiers and war workers when peace comes, and security, adequate housing and health protection for all.

On the other side of the picture we will have a greatly increased power over your life centralized in the federal government, taxes that will total many billions a year, payroll assessments and income limitations exceeding those now in effect and restrictions on individual freedom and decision. The government will look out for us, but make us pay for the service.

The old American ideals of thrift, the pioneer spirit to prepare in active years for the declining years of life are *out*. You can give from day to day without worry, for Uncle Sam will take care of you.

The government proposes to maintain a "partnership" with certain large corporate enterprises, while the super-new deal assessments and restrictions will probably compel many small businesses to shut up shop.

The definition of state socialism varies, but we can't help but wonder what the difference might be, in a general sort of way, between these proposals and some of the super-governments in Europe. The perfectly planned economy, with an all-powerful government guiding the life of every citizen, look fine on paper, but it seems a revolutionary departure from the American way of life as we knew it in the years gone by.—Red Bluff *News*, March 11.

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Rationed Doctors

The military services have had to take so many doctors that, from now on increasingly, medical services must be "rationed" for the duration. This does not mean that we should pass up necessary medication or surgery. It does mean that those with money should give up luxury service, in order that the available doctors and nurses may care for cases of real need.

In many communities there are serious shortages, arising sometimes from departure of too many doctors or from the mushrooming of cities and towns so that they have outgrown medical facilities.

Coöperation will help meet this crisis, like others.—Chico *Enterprise*, March 11.

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Keep Healthy For Victory

Doctors, Nurses, Hospitals Are Coöperating; Public Called Upon to Help

Health is becoming, increasingly, a personal responsibility and a patriotic duty. With one-third of the nation's doctors already in uniform, civilian health and working power may be threatened unless remedial steps are taken soon.

These steps should be directed toward proper distribution of doctors remaining in civilian practice, according to special abilities.

Meanwhile, if American standards of health are to be maintained, on a voluntary basis, it is the job of every citizen to protect his own health. This is a minimum contribution to America's strength.

The medical profession is giving its voluntary coöperation toward distributing doctor-power as widely and effectively as possible.

Working All the Time

"Doctors these days are not only working overtime; they are—most of them—working practically all the time and in total disregard of their own health," a government survey pointed out.

This is true of many physicians in San Francisco, despite the fact that this city has a relatively large number of doctors serving the civilian population compared with many other communities.

San Francisco physicians are helping the California Procurement and Assignment Service to locate doctors in nearby crowded war-industry areas where boom-town conditions prevail and the doctor shortage is critical.

Leaders of the local medical profession have issued strong recommendations to all local doctors on conservation of doctor-power, nurse-power and hospital space.

Group Nursing Plan

Group nursing allows one special nurse to care for two patients in cases of the type permitting a nurse to divide her time equally between them.

Organized nursing in San Francisco has likewise taken steps toward spreading care of hospital patients as widely as possible. The San Francisco County Nurses' Association has pledged that its private duty nurses will take general duty on a hospital staff at least one month out of each year, and the Association's Nurses' Registry is placing as many private duty nurses as possible on staff duty.

Retired nurses are being urged to return to active service.

Thus all who are concerned, professionally, with the protection of civilian health are doing their utmost to keep San Franciscans fit for the great tasks they are performing and the greater ones which they may soon be called upon to perform.—*Editorial* in San Francisco *Call-Bulletin*, April 26.

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DOCTOR SHORTAGE

On the basis of OWI's figures, the United States has 150,000 physicians to serve 135,000,000 people. One-third of these have joined the armed forces, where they are serving say seven million and a half men or about one-twentieth of the population. Of course, the armed services need more doctors in proportion to their numbers.

"The men in uniform," says OWI, have been and will continue to be the best cared for medically in the world." We want it this way. But this does not alter the fact, also reported by OWI, that the remaining two-thirds of the physicians are not enough for the 127,500,000 civilians. The soldiers and sailors, conveniently assembled, have a doctor to every 150 men. The civilians, in many cases badly scattered, have a doctor to every 1,275 men, women and children. Nor are the doctors distributed among the civilian population on this average. There are communities with 4,000 to one doctor, some smaller communities in reach of no physician.

This condition will grow worse as the armed forces increase. And this civilian population is the base and support of the armed services. Its health is essential to maintaining the Army and Navy. OWI, which has made a survey, says as yet there is no serious impairment of the health of the nation, "but unless we initiate some method of appraising the problem and deciding on the best plan to meet it, interference with mass production due to widespread sickness can be expected."

OWI makes no bones of laying some of the blame on recruitment of doctors for the armed services "without sufficient regard for the welfare of the civilian population." There is ground for thinking this is not the only case in which Army and Navy have ignored the needs of their civilian base. Some of the food shortages are apparently due to military buying and storage regardless.

The Army and Navy are not to be criticized on these points. They are obliged to go as far as they can. The blame lies on the Government for not maintaining a proper balance between military takings and civilian needs vital to military success. Nor is the government to be excused for not taking positive steps to redress the doctor situation. OWI says there are still enough physicians in private practice to control the health matter if they can be properly distributed. But nothing much has been done.—San Francisco *Chronicle*, March 30.

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INEXCUSABLE

Attempts to create fear that civilian medical service is on the verge of a breakdown, as a basis for advocacy of pet social theories in the field of medicine, are a grave threat to national morale and public health. This is the view of many eminent medical authorities, and is doubtlessly shared by millions of persons who are fed up with attacks on the doctors. The doctors have been doing a good job under difficult circumstances. By their ceaseless effort this has become the healthiest nation on earth. And now, when many of them are serving in the armed forces, is decidedly not the time to permit adoption of "Pearl Harbor" sneak measures that would result in the medical profession being put under the jurisdiction of some kind of a "czar."

An editorial in *Hygeia* says: ". . . The American medical profession began to plan in June, 1940, for the emergency. Doctors are being rationed even more scientifically than are gasoline, fuel and tires; far more scientifically than are the members of other professions and trades. The procurement and assignment service for physicians, dentists and veterinarians, merits the confidence and help of industrial leaders, public health and social service workers in allocating physicians to areas where there are apparent shortages."

Playing politics with public health is inexcusable.—Lincoln *News-Messenger*, February 25.

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LIVING UP TO TRADITION

The medical profession hasn't done a lot of talking about the "sacrifices" its members are making. And yet doctors, perhaps more than any other group next to the service men, are making real sacrifices in this war.

Thousands of them have voluntarily given up their practices. They live in the foxholes with the soldiers. They fight and die with the Navy and the Marines. They perform miracles amid blood and suffering. Gone is the business for which they spent so many years in preparation, often on a financial shoestring.

The doctors left at home are making sacrifices, too. Men who should be enjoying the leisurely aftermath of useful careers are back in harness working at a killing pace. They are on duty 24 hours a day—and they don't yell for time-and-a-half when Mrs. Jones is having a baby at 3 a. m.

The doctors are carrying out the tradition of American medicine in every emergency. Their example might well be followed by workers in other fields.—San Francisco *Organized Labor*, February 20.

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OUR NEIGHBORS' HEALTH

Few people realize how medical progress, such as has been made in the United States during the past generation, is being extended to the other American countries. Not only in commerce, but in health must North and South America be closely allied.

The publications of the Pan-American Union and the Pan-American Sanitary Bureau indicate that certain problems of the South American nations, which may be as much scientific as economic, demand the aid of their North American neighbors for ultimate solution.

Good health is fundamental to human progress. The downfall of many a nation may be definitely related to

malaria, plague, cholera or smallpox. Fortunately, the United States has been able to stamp out most of the great plagues which beset the rest of the world. Through philanthropic and other agencies it is giving its help wherever possible to aid other nations in meeting these hazards.

If we can help bring to other countries some of the blessings that have fallen to this nation as the result of a tireless, independent, self-sacrificing medical profession, we will be greatly benefiting ourselves. To illustrate, plague that is prevalent in Java, India and China, has been detected among rodents in the far west of the United States. It was carried here years ago on ships from the Far East. The mosquito that carries yellow fever has been found in airplanes flying into the United States from other countries.

A progressive and watchful medical profession, and the constant interchange of information from the health officials of all the Americas, is necessary for the salvation of all the American people.—Reedley *Exponent*, March 18.

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'Deterioration' in U. S. Health Feared

Washington.—The Office of War Information today disclosed the probability of a "slow deterioration" in the nation's health because of an acute lack of doctors in many communities.

"There is not at present a serious breakdown in health," the OWI said, "but unless we initiate some method of appraising the problem and deciding on the best plan to meet it, interference with war production due to widespread sickness can be expected."

Approximately one-third of the doctors in the United States—between 40,000 and 50,000—have joined the armed forces, the OWI said, and as the size of the Army and Navy increases more will be called.

"The men in uniform have been and will continue to be the best cared for medically in the world," it added.

But the problem of civilian health is increasing and in total war the health and working power of the civilian is as important as health and striking power of the man in the battle line. To offset lack of medical attention, attempts are being made to apportion the available supply of doctors as equitably as possible.

The OWI recently surveyed some 60 communities and 20 states where shortages of doctors have been reported. These conclusions were reached:

1. So far the health of the nation as a whole has not been seriously impaired by the doctor shortage. Doctors these days are not only working overtime; they are—most of them—working practically all the time and in total disregard of their own health.

2. The number of communities critically in need of doctors is not great compared with the total number, but those in need are among those most vital to the war effort.

3. In too many cases doctors were recruited for the armed services without sufficient regard for the welfare of the civilian population; enough remain in private practice to give adequate civilian care "provided they can be properly distributed numerically and according to special abilities."

4. The voluntary relocation of doctors has not resulted in a solution of the problem. In some communities local medical groups have resisted attempts to relocate outside doctors in their locality.

5. The situation as a whole is not now out of control, but unless remedial steps are taken soon it will grow progressively worse.

6. Luxury medicine is out for the duration. "We can no longer afford to call doctors for imaginary ailments."

The survey emphasized that medical shortages are not due in all cases to the war. For example, many rural areas have never had a sufficient number of doctors. In other regions, where the population has in many cases doubled and trebled due to war industry, conditions have not improved. The OWI found sections where there was only one doctor to 5,000 to 6,000 persons, with the people frankly worried over what might happen if any number of them became ill at the same time.

In a county on the West Coast, near a Navy yard, the survey reports an increase in population from 44,000 to 110,000, and during 1943 it is expected that 25,000 more persons will move into this area. The present ratio is one doctor to 4,000 persons, and the hospital situation is described as "terrible."—San Francisco *News*, March 29.

Press Clippings.—Some news items from the daily press on matters related to medical practice follow:

Irwin Center Sends Plasma to Services

The Irwin Memorial Blood Bank of the San Francisco County Medical Society supplied 565 units of whole blood to Bay Area hospitals during March, Dr. Curtis E. Smith, chairman of the Society's Blood Bank Commission, announced yesterday.

Increased donations are needed, he said, to supply local needs and the various services. There were 1052 donors during the month, but more are needed.

Dr. Smith announced that 859 units of frozen plasma is maintained in San Francisco hospitals for use in an emergency and that although 18,000 persons have given blood since the bank was opened in June, 1941, more donations are needed because of increased demands.

"What the Red Cross is doing on the fighting fronts, the Irwin Blood Bank is doing on the home front," said Dr. Smith.

"Bank your blood while you can; you may some day need it yourself," is the slogan of the Irwin Bank, which is located at 2180 Washington Street.—San Francisco *Chronicle*, April 25.

S. F. Doctor New Head of Industrial Surgeons

Dr. C. A. Walker of San Francisco, Chief Surgeon of the Southern Pacific, yesterday was elected president of the Western Association of Industrial Physicians and Surgeons at its third annual convention in the Biltmore Hotel.

Dr. Walker succeeds Dr. Benjamin J. Frees of Los Angeles, who was elected to the board of directors.

Dr. Rutherford T. Johnstone of Los Angeles was reelected secretary and Dr. J. M. McCullough of Crockett was reëlected treasurer.

Dr. Richard Scofield was elected to the board of directors, to which Doctors Robert T. Legge of the Berkeley campus of the University of California and John D. Ball of Santa Ana were reëlected.—San Francisco *Examiner*, April 30.

Labor-Management Unity Needful for Industrial Medical Service

New York (FP.)—Coöperation of labor, management and the community is needed to end absenteeism from illness and accidents which, conservative estimates show, cost 500,000,000 man-days in American production during 1942.

In spite of the great need for coördinated health services and medical care, labor, management, and other community interests are attacking the problem separately. Old barriers keeping labor, management and medicine from discussing health care for workers must be torn down—at least for the duration.

There has been so much muddling in the handling of medical manpower that a nationwide shortage of physicians in industry and civilian life is threatened. In many sections this shortage already exists. . . .

California Shows Way

Some things have been accomplished. In California, the Federal Public Housing Authority and the California Physicians' Service arranged a plan of health centers in housing projects for defense workers. Payments to the plan are collected with each month's rent.

Unfortunately, management is not yet completely in the picture. All sections of the community must pull together on the health front, because the whole community

is at war. The health of any section should be of vital concern to all other sections. . . .

There is another important reason for labor to increase its interst in health and medical care problems now. In any American Beveridge plan, provisions for health and medical care will occupy an important place. Good medical care will no longer be a luxury. Medicine will be made democratic, but only if labor works to make it so.—San Diego *Labor Leader.*

Talk on Nursery Plan Heard by Social Workers

More than 200 social workers representing Federal, State and municipal agencies met at the State Building yesterday for detailed instructions on the application of the Lanham Act, under which Federal funds are being allocated for the care of children of war-working mothers.

The meeting was conducted by Mrs. Florence Kerr of Washington, D. C., assistant administrator of the War Public Services, an office under the Federal Works Agency. She was assisted by Mrs. Mary H. Isham of Salt Lake City, western regional director; Frank G. Morrison, in charge of the nursery school program in this area, and Wallace Campbell, regional finance examiner, of the same organization.

Fund Appropriated

The social workers were told that approximately $75,000,000 has been allocated for the establishment of nursery schools for children from 2 to 5 years of age and for recreational activities for children of school age throughout the nation. In California, Mrs. Kerr said, the State and other agencies are expected to contribute one-half the operational costs of the program.

Thus far only two schools using Lanham Act money are in operation in California, one in Bellflower and the other in Vallejo.—Los Angeles *Times.*

War Meal Danger Told

You may be getting by now, but if you don't watch your step during this wartime, you may be laying the basis for digestive disorders later on.

That word of warning was brought here yesterday by Dr. George H. Kress, of San Francisco, California Medical Association secretary, who arrived at the Biltmore to make arrangements for the Association's convention, May 2 and 3.

Reporting nutritive deficiency diseases will occupy a prominent place in the convention program, Dr. Kress declared:

"Due to the extensive war work in Los Angeles, including night shifts and irregular hours, this area may be particularly subject to such diseases because of irregularly spaced meals."—Los Angeles *Examiner,* April 13.

Medical Insurance Plan

New York, April 5.—(AP.)—Mayor F. H. La Guardia announced today that he has drafted a citywide medical service insurance plan and would appoint a committee this week to work out the details.—San Francisco *Call-Bulletin,* April 6.

Public Aid to the Needy

Years of WPA Cost Less Than Months of War

Washington, April 25.—(AP.)—Relief in the form of doles or payments for work on public projects cost the American taxpayer nearly $25,000,000,000 during the 1933-42 decade.

That sum, including money spent by federal, state and local governments, exceeds the entire national debt through 1933, but is less than a third of what the federal government alone will spend in the wartime fiscal year ending June 30.

Costs Not Included

Shown in data compiled by the Social Security Board, the sum covers "payments to recipients of public assistance and earnings of persons employed under Federal work programs in the continental United States, January, 1933-December, 1942." It does not take into account money spent for administrative purposes or for purchase of materials.

Biggest single item in the $24,829,692,000 outlay was $9,042,928,000 in Federal funds paid those on the rolls of the Works Project Administration.

The second greatest single item was $6,055,431,000 credited by the Security Board to "general assistance," provided exclusively by state and local governments without matching federal funds.

Third was $3,024,251,000 expended on old age pensions, with the federal and state governments sharing the cost, and fourth, $2,139,008,000 to enrollees of the Civilian Conservation Corps.

The Blind Helped

Other expenditures in the ten-year span were given as follows:

Aid to dependent children, $900,306,000; aid to the blind, $158,976,000; federal emergency relief administration (predecessor to the WPA), $186,158,000; Farm Security Administration, $137,268,000; National Youth Administration, $508,492,000; Civil Works Program (also a WPA forerunner) $718,016, and projects operated by various Federal agencies on emergency funds, $1,958,858,000.—San Francisco *Chronicle.*

Health and Socialism

Northwestern University has just published a report, based on an exhaustive study made by members of its staff, of compulsory health insurance in the United States. The report should be read by every American citizen. It warns of dangers inherent in social schemes that envisage government as the sole dispenser of medical care at the expense of the general taxpayer. It stresses the need for treading cautiously lest in a hasty grab for Utopia, social and economic progress be lost and medical standards irretrievably lowered.

In its practical application, compulsory health insurance reverses the normal doctor-patient relationship. At present the patient is anxious to get well and get back to work. The doctor, too, is anxious to secure quick recovery for his patient. He knows that big doctor bills and lengthy illness do not contribute favorably to his reputation in the patient's mind. Under compulsory health insurance, the patient is paid by the government (taxpayers) for being sick. The longer the sickness, the more he receives. A "good" doctor is liberal in certifying clients as eligible to receive cash benefits. On the other hand, an ethical doctor often arouses the antagonism of clients by refusing unjustified benefits. Under the pressure of "free money" the integrity of patient and doctor deteriorates. This is a fact borne out by experience in nations having compulsory health insurance.

Aside from a tendency to lower medical standards, compulsory health insurance, if adopted, would be one more move toward socialism. Its advocates openly admit that it is but a short step from there to total government domination of medicine. Socialized medicine would result in a vast expansion of bureaucracy, and human nature being as it is, the doctors themselves would be forced to become politicians as a requisite of success. No longer would medical skill be the sole criterion of advancement.—Merced *Sun-Star,* April 10.

MEDICAL JURISPRUDENCE†

HARTLEY F. PEART, ESQ.
San Francisco

Legal Restraints on Contraception

A recent decision of the United States Supreme Court, *Tileston v. Ullman,* 87 L. Ed. Advance Opinions 443, calls attention to the fact that there are still some states in the Union where it is unlawful for a person to use contraceptives and equally unlawful for a physician or surgeon to prescribe or advise as to their use by even a married woman. The constitutionality of a law of the State of Connecticut forbidding "the use by any person of any drug, medicinal article or instrument for the purposes of preventing con-

† Editor's Note.—This department of CALIFORNIA AND WESTERN MEDICINE, presenting copy submitted by Hartley F. Peart, Esq., will contain excerpts from the syllabi of recent decisions and analyses of legal points and procedures of interest to the profession.

ception" and making liable to prosecution any person who "shall assist, abet or counsel another to commit such an offense" was questioned in the case of *Tileston v. Ullman*, 129 Conn. 84, 26 Atl. (2d) 582, decided May 22, 1942, by the Connecticut court and an appeal was taken to the Supreme Court of the United States from the decision upholding the validity of the statute.

The plaintiff in the case, a licensed physician, brought an action in the state court for a judgment interpreting the above statute and declaring it unconstitutional if it should be construed to make it unlawful for him to prescribe the use of contraceptive devices for married women living with their husbands who came to him as patients in cases in which his professional judgment dictated that such treatment be given in order to preserve the life or health of the woman patient. Three cases were specified by the physician, in each of which the patient suffered from some physical disability, such as high blood pressure, tuberculosis or a generally weakened condition as a result of previous pregnancies, which would be seriously and dangerously affected by the patient becoming pregnant. The plaintiff physician requested the state court to imply an exception in the stated law to allow the prescription of contraceptives in those cases where it was necessary to preserve the life or health of the patient and in support of this construction of the law advanced the theory that if the law were not so interpreted the Connecticut statute should be held unconstitutional as unreasonable and violative of the due process of law clause of the Fourteenth Amendment. In a previous case, the court had refused to construe the section in question as allowing a duly licensed physician to prescribe the use of contraceptives where "the general health and well being of the patient require it." In the instant case, the court was asked, however, to adopt a construction of the statute which would permit the prescription and use of contraceptives in cases where not only the general health of the patient was involved but also there was imminent danger of loss of life, the need for such action being more obvious in such cases.

The Connecticut statute was adopted originally in 1879 and the court recognized that during the intervening period a considerable change had taken place in the views of a great number of people on the subject. Notwithstanding this change in social outlook, the court refused to read any such exception into the statute and clearly held that even in cases where the life or health of a patient might be seriously endangered, a Connecticut physician would be subject to criminal prosecution for advising such a patient in the use of any means to prevent conception and the resulting pregnancy.

The plaintiff physician had argued that such a construction of the statute would be violative of the due process of law clause because it would be unreasonable to forbid the prescription of contraceptives in cases where professional opinion was unanimous to the effect that the safest medical treatment which could be prescribed for a given patient would be to advise of proper methods of preventing conception which can be used safely and effectively and thus to avert the unfortunate consequences which might flow from pregnancy. It was pointed out, however, that there was another remedy of certain result and that was to advise complete abstinence. The court said that the reasonableness of this latter course was a question for the legislature and until such time as the legislature chose to act by amending the law the court could not sanction conduct in direct conflict with the words of the statute.

On appeal to the United States Supreme Court in *Tileston v. Ullman*, 87 Law Ed. No. 8, p. 443, it was held on February 1, 1943, that the plaintiff physician had no standing in court to question the constitutionality of the statute because the sole constitutional attack under the Fourteenth Amendment had been confined to an allegation that the law as interpreted might deprive the patients of their lives. Since the patients were not parties to the action, the court ruled that the physician had no standing in court to secure an adjudication "of his patients' constitutional right to life, which they do not assert in their own behalf."

In view of this ruling unfortunately the court did not consider it necessary to pass upon the general validity of the Connecticut statute. Consequently, it is still law in Connecticut that even though a woman patient's life would be seriously endangered by pregnancy, a physician is not allowed to prescribe or advise her in the use of contraceptives.

LETTERS†

Concerning San Francisco Chapter of Pan American Medical Association:

PAN AMERICAN MEDICAL ASSOCIATION

San Francisco, March 29, 1943.

At a recent business meeting of the Association, the following officers were elected: President, Harry Alderson; Vice-President, John P. Strickler; Treasurer, Edmund Butler; Secretary, Salvatore Lucia. Regional Administrators of California: S. H. Babington, Berkeley; Junius B. Harris, Sacramento; Charles P. Mathé, San Francisco; Albert Soiland, Los Angeles; and Francis Scott Smyth, San Francisco.

Last fall, a joint reception was held at the Bohemian Club in honor of Dr. Braun-Menendez, by members of our Association and the Herzstein Committee of the University of California and Stanford University Medical Schools. Doctor Braun-Menendez is a famous physiologist from Argentina, whose researches on renal hypertension have achieved world-wide recognition.

The annual dinner meeting of the Association was held at the Bohemian Club on January 9, 1943, honoring

† CALIFORNIA AND WESTERN MEDICINE does not hold itself responsible for views expressed in articles or letters when signed by the author.

the consular representatives of Latin America and visiting Latin American physicians and students. The Association received a great tribute in the fact that all the Latin American consuls were present, excepting two, who could not attend on account of illness. Many Latin American physicians were in attendance. . . .

Dr. Francis Scott Smyth, Dean of the University of California Medical School, gave a most instructive and interesting address on "Inter-American Medical Relations." Sr. Juan José Martinez Lacayo, Dean of the Latin American Consular Corps, spoke in Spanish on the wholehearted collaboration of the Latin American consuls with the officers of the Pan American Medical Association. The Honorable Annibal de Saboia Lima, Consul General of Brazil, expressed the appreciation of his country for the assistance of American physicians in combating infectious diseases in Brazil. The Honorable Sr. Fernando Berckemeyer, Consul General of Peru, and the Honorable Martín Luis Drago, Consul General of Argentina, voiced their recognition of the catholic work that the members of the medical profession are doing towards alleviation of human suffering in the western hemisphere.

Dr. Joseph Jordan Eller, Director General of the Association, has informed us that the Eighth Congress of the Association will be held at the Hotel Waldorf-Astoria in New York in September. The Congress will be devoted entirely to war medical problems with the idea of consolidating our medical efforts on a hemispheral basis. All branches of medicine and surgery will be represented and the most representative physicians from South America and Central America, as well as North America, will be present. The Congress will devote one or two days to the problems of the physicians in the Armed Services. Such subjects as: contagious diseases, treatment of burns, blood banks, sulfa drug therapy, traumatic and plastic surgery, together with dental problems, will be included in the program.

The chapter has 120 active members residing in central California. Of these, fourteen are in active service in the armed forces of our country. . . .

SALVATORE P. LUCIA, M. D., *Secretary.*

Concerning Medical Supplies to Soviet Russia:

(COPY)

RUSSIAN WAR RELIEF, INC.

Registered with President's War Relief Control Board No. 547

San Francisco, April 28, 1943.

To the Editor:—Through Russian War Relief there is now being organized in every State of the Union a specific and concrete method for the attainment of that unity and understanding between our Allies which is a prerequisite for victory.

Americans, through our organization, have sent invaluable aid to the fighting forces and the people of the Soviet Union. Over 70 per cent of this aid has been in the form of medical supplies. Now, as part of a tribute to Russia Celebration during May and June, we are asking for five million or more Americans to write a personal letter to a Soviet citizen. This plan was suggested by receipt in headquarters and by our contributors receiving hundreds of letters from Soviet citizens who have received clothing, food, medicines and other supplies contributed by Americans. These letters thanked the contributors, then in almost every case said: "I wish you would write to me."

Will you help in this National effort by publishing this letter in your Journal? It is an invitation to every doctor to send a letter to Russian War Relief, 422 Sutter Street, San Francisco. Each letter will be given to a doctor in Russia and will be translated by committees, teachers or a friend.

Yours very truly,
PHILLIPS DAVIES, *Chairman,*
Tribute to Russia Celebration
For Northern California Division.
422 Sutter Street.

Concerning a Fake Solicitor (Health and Accident Policies):

(COPY)

Visalia, California, April 12, 1943.

To the Editor:—A man by the name of C. A. Kelley is soliciting the doctors with what he claims is a noncancellable health and accident policy issued by the Income Guaranty Co., of South Bend, Indiana. The reason I write you is that he claims the company to be a subsidiary of Medical Protective of Fort Wayne, Indiana. He was so glib that I became suspicious and wrote Medical Protective.

I am advised that there is no connection whatsoever between the companies and that this individual has done this before. I thought it might be wise to report this to you so that it might be given publicity in CALIFORNIA AND WESTERN MEDICINE to protect others who might be tempted to buy.

Margaret joins me in sending best wishes.

Sincerely yours,
GEORGE F. KEIPER.

Concerning Physicians' Gasoline Allowance:

Following are excerpts from a letter addressed to the San Francisco County Medical Society by Legal Counsel Hartley F. Peart:

"We have received several inquiries from members of the Society as to what use they may make of additional gasoline allowed by their 'C' ration books.

"Under the regulations issued by the OPA, the preferred mileage allowed to physicians is limited to that necessary in making professional calls upon patients and the physician is not even permitted to use gasoline allowed by his 'C' book to attend medical conventions or meetings of the profession.

"In this connection, you may wish to call the attention of the members of the Society to the following requirements of the applicable regulations:

" 'Travel by physician between home and office. Although a physician is not entitled to preferred mileage for travel between his home and office merely to keep office hours and to treat patients, he may be allowed preferred mileage for professional calls even though travel on such calls require occasional visits to his office to pick up equipment or to obtain directions and information necessary to make such calls.

" 'Travel by physicians, surgeons, etc., for conferences, conventions or courses of study. Travel to or from conferences or conventions or in attending courses of study may not be included in preferred mileage, even though such activities may better equip such persons to carry on their professional work.

" 'Travel by supervisors and agency heads. Mileage driven by supervisors and agency heads who direct the work of physicians and surgeons may not be allowed as preferred mileage since such travel is not for making necessary professional calls, nor is it travel between offices maintained by them.' "

TWENTY-FIVE YEARS AGO†

EXCERPTS FROM OUR STATE MEDICAL JOURNAL

Vol. XVI, No. 5, May, 1918

EXCERPTS FROM EDITORIAL NOTES

The Del Monte Meeting.—Reports of the annual meeting of the California State Medical Society will appear in the June issue of the JOURNAL. Suffice it to say that the meeting was one of the best from every standpoint that has yet been held. Many matters of vital importance came up for decision and the results will be far-reaching. Weather, location, and the spirit of the times combined to lend special distinction to its deliberations. . . .

Continuing Need for Surgeons in Medical Reserve Corps of Army.—California with a medical population of 5,687 has given 783 to the Army. This is 13.8 per cent. whereas our real quota should have been nearer 20 per cent. Not only is this number, then, somewhat below what it should have been, but it leaves the state rather low in the list of states in regard to this matter. California and Connecticut have each 13.8 per cent of its medical population in the Army, and so are contestants for the twenty-ninth position. Nevada still ranks first with 154 medical men in the state and 37 in the Army, which is 24 per cent of its medical population. Arizona is second, Montana third, and Pennsylvania fourth in the list of percentages. . . .

There will be added to the Army this year about three-quarters of a million men. These will require about 7,500 surgeons. The Council of National Defense at the present time is asking California for at least 200 more surgeons, but looking this matter squarely in the face it would seem as if 400 or even 500 would be more appropriate. . . .

Report of Provost Marshal General on First Draft.—Under date of December 20, 1917, the Provost Marshal General has issued a report of the results of the first draft for the Army under the Selective Service Law. The report is compendious and will afford material for much interesting study. On June 5, 1917, there were enrolled a total of 9,586,508 men, of whom 3,082,949 were examined. Of this latter figure 1,057,363 were certified for military service. Of those so certified, 252,294 failed to appear when called for examination and according to the law were accordingly certified for service. This leaves, excluding also certain other minor classes, a total of 2,510,706 men who were actually examined by local boards. Of these, 730,756, or 29.11 per cent were rejected for physical incapacity. Of these, 22,989, or 5.8 per cent, were rejected after being sent to cantonments by the local examining boards. Of the California men, 26.17 per cent were disqualified for physical reasons.

Practically one-half of those called claimed exemption on some ground and of these 39 per cent were exempted, constituting 77.86 per cent of the total claims made for exemption. Less than 6,000 arrests were made for failure to register.

The total expense of the draft was $5,211,965.38. The average cost per registrant was $1.54, per man called was $1.69, and per man accepted for service was $4.93.

(Continued in Front Advertising Section, Page 14)

† This column strives to mirror the work and aims of colleagues who bore the brunt of Association activities some twenty-five years ago. It is hoped that such presentation will be of interest to both old and new members.

BOARD OF MEDICAL EXAMINERS OF THE STATE OF CALIFORNIA†

By F. N. SCATENA, M. D.
Secretary-Treasurer

Board Proceedings

In conformity with the policy of the Board of Medical Examiners to open all bottlenecks in the licensing of doctors in the State, an oral examination was held in Los Angeles on April 8, 1943. Such oral examinations are required by law of doctors applying for reciprocity on some other State of the United States, whose certificate in said State is dated more than ten years previous to the filing date in California.

The Board of Medical Examiners also went on record at its recent meeting in Los Angeles that it would give additional written examinations to candidates for licensure, whenever a sufficient number of such applications are on file, this also in an endeavor to aid in every possible way in the war effort.

News

"License of Dr. Thomas D. Wyatt to practice medicine has been restored by a writ of mandate issued by Superior Judge Edward Murphy in San Francisco, it was revealed here yesterday. The doctor, who has twice lost his license for allegedly performing illegal operations, brought action against the State Board of Medical Examiners, claiming they had exceeded their jurisdiction in revoking his license the second time. . . ." (Press dispatch from Redding, in Sacramento *Union*, March 24, 1943.)

"Warning all boards to scrutinize closely all applications for additional food rations made on a doctor's prescription, Paul Barksdale d'Orr, OPA ration chief for the Southland today listed the three types of doctors who are allowed to 'prescribe' under OPA regulations. The trio include a doctor of medicine, signing and entitled to sign M.D.; an osteopathic physician and surgeon, signing and entitled to sign physician and surgeon, D.O., or a doctor of dental surgery, signing or entitled to sign D.D.S. . . ." (Alhambra *Post-Advocate*, March 18, 1943.)

"The requirement that licensed state osteopaths have at least 30 hours of 'professional educational experience' every year should be abandoned, the assembly governmental efficiency and economy committee ruled. The bill, eliminating the annual 'refresher training' provision, was authored by Assemblyman Everett Burkhalter, Burbank, and given 'do pass' approval. It was opposed by the California Osteopathic Association. . . ." (Sacramento *Union*, March 18, 1943.)

"Approval of a plan advanced by the city council for employment of physicians to give physical examinations to prisoners when they are booked, and when they are discharged from city jails, has been voted by the police commission. . . . The suggestion was submitted by the council to the commission as the result of consideration

(Continued in Back Advertising Section, Page 30)

† The office addresses of the California State Board of Medical Examiners are printed in the roster on advertising page 6. News Items are submitted by the Secretary of the Board.